

# AMERICAN MEDICAL TIMES

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## ANNOUNCEMENT.

In presenting the first number of the **American Medical Times**, to the notice of the medical profession the publishers particularly call attention to the fact, that it is the continuation, in a weekly series, of the **New York Journal of Medicine**, whose career commenced seventeen years ago, and which has, without a single interruption, appeared regularly up to the present time, and now circulates largely in every State in the Union.

For an explanation of the motives which have led to the alteration in the form and issue of the Journal we refer to the leading editorial in the present number.

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The dose of Santonine, for an adult, is 5 to 10 grains; of Jalapine, 3 to 6 grains.

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gees of Pyrophosphate of Iron.—This preparation, representing two of the most important elements of the human system, supplies a therapeutic want, which had long been felt by the Physicians. The report of the Academy of Medicine of Paris, and the general favor with which it has been hailed by every Physician who has used it, are a sufficient proof of its merits.

This preparation is used with success in cases of general debility, particularly those attended with nervous prostration, Neuralgia, Leucorrhœa, Phthisis, &c. &c. The Syrup contains 1 grain of Pyrophosphate of Iron per teaspoonful.

The dose is a dessert spoonful for an adult, and a teaspoonful for a child, three times a day.

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Cod Liver Oil.—This new preparation, derives its superiority over the ordinary Cod Liver Oil from the addition of Iodine, Cromine, and Phosphorus, which are chemically combined with it.

In taste, smell, and color, it is like pure natural oil, but owing to the smallness of the dose required, it is much less apt to nauseate the stomach in delicate persons. It has been used with marked success by many of our first physicians in various diseases of the respiratory organs, in scrofulous and rheumatic affection, and in all cases where the pure oil is usually prescribed.

This oil contains, besides its natural constituents, eight grains of iodine and one grain each of bromine and phosphorus per pint.

The dose for an adult is a dessert spoonful, which may be gradually increased to a tablespoonful, three times a day, for children in proportion.



## Original Lectures.

### CLINICAL LECTURE ON SYPHILITIC DISEASE OF THE LARYNX.

DELIVERED AT THE NEW YORK HOSPITAL.

BY

WM. H. VAN BUREN, M.D.,

SURGEON TO THE HOSPITAL.

GENTLEMEN:—In our last public visit you remember we examined several cases of syphilis, and that there was one patient to whom I called your attention for a moment, who wore a tube in his trachea. That case belongs to a very interesting class, which is, perhaps, too much neglected, and I have thought it worth our while to spend a few moments in studying its history, and the character of the affection of the larynx which rendered the insertion of the tube necessary.

This affection is known by the name of syphilitic disease of the larynx. It is one of those forms of syphilis which, happily for humanity, is rare, but still it is not uncommon to find in a hospital of any size, one or two men as nurses, wearing these tubes. I remember very distinctly the case of a nurse in La Charité Hospital, of Paris, twenty years ago, who had worn the tube for a number of years.

The term laryngitis is applied correctly to purely inflammatory affections. The disease, however, now under consideration is not an inflammation of the larynx, but is the result of the manifestation of syphilis in that part of the organism.

In order that you may recall all the features of this case I will read an abstract of it, which I have received from my colleague, Dr. Markoe.

JOHN BARBER, *ætat.* 35, English seaman, admitted to the New York Hospital, Oct., 1859, with syphilitic sore-throat and laryngeal disease. Had chancre six years ago, followed by secondary symptoms, amongst which was sore-throat; which has since then recurred six or seven times, but the larynx was not involved until the last attack in 1858, for which he was treated in the Hospital; he had then hoarseness and tenderness of the larynx on external pressure, which yielded to anti-syphilitic treatment, and he was discharged, apparently cured, in January, 1859. In about nine months he was readmitted with his present attack, which, like the former ones, was characterized by ulceration of fauces, with hoarseness, pain, and tenderness about the larynx, cough, mucous expectoration, and occasional paroxysms of dyspnoea. The attack was more severe than any of his previous ones, but it gradually yielded and he assumed the duties of a nurse in the Hospital; treatment employed: mild mercurials, cinnabar fumigations, iodide of potassium. About the 1st of February, the throat was again attacked, and still more severely, by ulceration of pharynx, hoarseness, dyspnoea, and extreme tenderness of larynx.

On examination by the finger the epiglottis felt, "irregular, contracted, and thickened." On February 8th, the following was the note taken of the case: "Patient cannot lie down through dyspnoea; expiration seems to be effected with more difficulty than inspiration; expectoration very copious—of viscid muco-purulent matter, and effected with much pain; deglutition excessively difficult—can swallow fluids only."

Under the steady and cautious use of the remedies already mentioned these extreme symptoms yielded during the following week, and the patient's condition improved somewhat, his gums being distinctly sore from mercury at the time of the amendment. But the improvement was not progressive; he still suffered from frequent paroxysms of

dyspnoea, relieved by copious expectoration; the amount of this latter was excessive; his pulse continued above one hundred, with much emaciation and debility, and great difficulty in swallowing; lungs free from disease. In this condition the operation of bronchotomy was decided upon with the view simply of facilitating the function of respiration, and, by placing the larynx at rest, of contributing to its restoration. The operation was done on the 20th of February (by my colleague Dr. Markoe, who was then on duty, and to whose note of the case I am indebted for the facts just stated). A double canula was introduced through the crico-thyroid membrane.

The immediate consequences of the operation were most favorable. Expectoration diminished, together with the constant and annoying hawking, spitting, and coughing; breathing entirely free. Capacity to take solid food returned in a few days, and sleep was undisturbed. On the 27th his pulse had fallen to 90 (from 120), and on the 9th of March he is reported to be gaining rapidly, to have lost his phthisical look, and to be growing fat.

Now, gentlemen, you have the case before you. From the last note, March 9th, to the present day (May 25th), he has been doing perfectly well. He breathes entirely through this double canula. The larynx being, as it were, thrown out of gear, the man cannot speak unless he closes the opening into the trachea and throws the column of air past the vocal cords, which, in consequence of the constriction of the tube, can easily be done.

The wound through which the tube is lodged in the trachea is very apt to close when the instrument is left out any time; two hours is sufficient to make the granulations which surround the opening to contract sensibly, and if left out for twenty-four hours it might be impossible to return it.

I remember one patient upon whom I operated twelve years ago, in Bellevue Hospital, for this same disease. One day the House Surgeon, having removed the tube for the purpose of cleaning it, was suddenly called from the ward to attend an obstetrical case, and found it impossible for him to return immediately. In less than two hours after he was sent for in great haste, with the intelligence that the patient who had been thus left was dying. On arriving in the ward he found that the wound had contracted to such an extent, as almost to prevent his breathing; the face was dusky, the lips livid, and there were all the symptoms present of impending suffocation. The Dr. attempted to reintroduce the tube, but found that it was impossible. I arrived about that time, having been sent for in great haste, and with the aid of a probe-pointed bistoury succeeded in replacing the tube. As soon as this was done, the patient breathed freely, the livid hue left his countenance, and he was restored to his former comfortable condition.

In making a few remarks on this case, I wish to discuss, first, the pathology of the disease; second, what are the chances of an ultimate cure, and, finally, what is the value of the operation of bronchotomy in this condition.

As to the nature of the affection, it is properly termed syphilitic disease of the larynx. It is a disease which is not treated much of in text-books, and consequently to the mind of the student its character is apt to be left in a state of obscurity. It is for this reason that I have asked you to study the disease with me this morning.

Syphilis chooses the throat as one of its favorite localities. We all know that sore throat is very apt to occur after an infecting chancre; that in many cases it is either persistent or is very likely to return. We know also that such affections of the throat present themselves in every phase, from a simple erythematous blush to extensive and destructive ulcerations. We have frequently seen this diseased condition occupy every part of the fauces, sometimes extending into the Eustachian tubes, producing deafness, or again perforating the velum, and not unfrequently causing it to adhere to the back of the pharynx. I had under my care a

case in the adjoining ward, in which the *velum pendulum palati* was adherent to the back part of the pharynx in such a way as to cut off all communication between the mouth and posterior nares. The breath had literally "departed from his nostrils," and consequently he lost the power of smell.

I refer to this case merely to show how important functions may be interfered with by the ravages of this destructive disease.

This same disease of the throat is liable to extend and involve the larynx, affecting in succession the mucous membrane of the epiglottis, and of the arytenoid cartilages, and attacking the *chorda vocales*, in which case there is alteration of the voice present, or, narrowing of the chink of the glottis, with obstruction of respiration. This affection of the larynx, then, is identical in character with that of the throat, by which it is almost invariably preceded. The fact is one of sufficient importance to warrant its reiteration, viz.: that you rarely find syphilitic laryngitis occurring before, or unaccompanied by, ulceration of the throat.

Now, in reference to the forms that the disease puts on. You may see it presenting itself with simple hoarseness of voice (*vox rauca*), which is a symptom somewhat characteristic of syphilis; then again, it may be nothing but an ordinary catarrh of the membrane, and this is its mildest form. If the patient has the disease sufficiently developed in his system, it will present itself either in permanent thickening of the mucous tissue, or advance to positive ulceration. These ulcerations are liable to occur in any part of the surface of the larynx, and they follow the general law of syphilitic ulcerations in other parts of the body, concerning the characters of which you have had abundance of opportunities to learn. We have here upon the table an instance in which the epiglottis has been entirely destroyed by this disease.

I will mention, in passing, that a loss of this part (epiglottis) does not interfere with deglutition. There is a specimen in the museum of Dr. Mott, in which the epiglottis was found wanting at the post-mortem examination, but in which during the life of the patient there was no symptom that led to the suspicion of such a deficiency.

These ulcerations may extend from the larynx unto the trachea, bronchi, or even into the lung tissue itself. These facts are pretty well substantiated by the recent researches in Germany and France, more especially by Virchow of Berlin, Depaul, Diday, and Gubler.

It is probable that as our attention is directed more and more to this subject, it will be found that there are certain forms of bronchitis, if not pneumonia or phthisis, that have their origin in alterations depending upon the syphilitic poison. This is a fact that has been in a measure proved by Virchow, one of the greatest pathologists now living, and whom we should consider, from the rare opportunities he has of investigating the disease, as the highest authority upon the subject.

Syphilis, as I remarked before, prefers certain localities to others—thus upon the skin we notice eruptions, most frequently at the roots of the hair, around the face, and in the neighborhood of the genital organs. In like manner it has its points of preference upon the mucous membrane, and is most frequently met with in the throat, while in the intestinal canal it is very rarely seen, except at the lower end of the rectum.

In regard to the cause of these eruptions or ulcers, I can only say that they seem to be the result of an effort on the part of the economy to eliminate a poison; the secreting glands being irritated to a greater or less degree in consequence. The striking tendency of these eruptions is to run into ulcerations; they, however, are not of a phagedenic character, yielding readily to the anti-syphilitic treatment. Neither do they involve danger to life, unless by their situation they interfere with the function of some vital organ. In connexion with this tendency to ulceration, there is an effusion of a certain material which is as characteristic of syphilis as are tubercles of phthisis. I refer to the *gummy tumor* of the French. This peculiar exudation is deposited

under the skin in masses, going to form papulae, elevations of greater or less size, even entering into the constitution of soft nodes. These deposits are not unfrequently met with in the substance of the tongue, and Ricord refers to one situated in the substance of the heart itself. This, then, is one of the peculiarities of syphilis.

The worst form of syphilitic laryngitis is that in which not only the mucous membrane but the perichondrium is the seat of the disease. The cartilage of course dies, and if the extent of such destruction is by any means considerable, the case must terminate fatally. The existence of this disease is made out without difficulty, from the odor of the breath, which is quite peculiar, being of even a more rancid odor than that which emanates from necrosed bone.

In the case that I alluded to as having been operated upon some ten years ago in Bellevue, there was an exfoliation of bone from the back part of the cricoid cartilage which of course had become ossified. The cartilages of the larynx are, as you know, liable to ossification, and true bone may be found in the posterior portion of the cricoid cartilage at any time after the twenty-fifth year.

In regard to the diagnosis of syphilitic laryngitis. There are certain diseases of the larynx which may be mistaken for syphilitic disease, but I have alluded to one fact, that if remembered, will always lead to a right conclusion. It is this: You cannot have syphilitic disease of the larynx except the throat is the part first affected. This fact can generally be determined by an inspection of the part. Whenever you have cough with laryngeal trouble, and syphilitic antecedents, there can be no difficulty in arriving at a proper conclusion. There are, however, certain forms of disease which may give rise to some doubt in your mind. I allude more particularly to the disease known as *phthisis laryngea*. You know, in the latter stages of the disease, that phthisis is very apt to affect the larynx in consequence of the irritating quality of the material expectorated; this, however, is only a concomitant ulceration, and has nothing to do with the subject in hand. The true laryngeal phthisis was first described by Porter of Dublin, who considers it an alteration of the cartilage of the larynx, by means of which death of the parts takes place, giving rise to the formation of abscess, attended with difficult breathing, pain in deglutition, hectic fever, and the like. Generally speaking, the breath gives the odor of dead cartilage, the thickening around the larynx, and also the presence of an abscess behind is quite characteristic. This disease, however, is very rare, occurring in middle-aged persons; generally follows some catarrhal affection; occasionally it may be brought on as the result of violence. Sometimes the antecedent history is all you can rely upon in coming to a determination.

With regard to the means of examining the larynx, there is a word to be said:—When the epiglottis or upper opening of the organ is affected, you can often, with your finger, feel the lesion. This is one of those little pieces of mechanical dexterity that you must accustom yourselves to, and it is one of those accomplishments which can be acquired only by practice. A very good plan is to practise palpation upon the cadaver in the absence of other opportunities. Another means of throwing light upon these affections is the use of the *laryngoscope*. I hold in my hand one of the varieties of a form of instrument which is of a great deal of use. Here is a mirror pierced through its centre by a small hole, and here are several steel plates attached to handles. The patient is placed with his back to the light, and you in front of him look through the opening in the centre of the mirror at the throat, which is illuminated by the reflected light. The parts around the top of the larynx are reflected on the surface of the steel mirrors, which should be dipped in warm water before using, to prevent cloudiness from vapor.

With regard to the prognosis in this disease what have we to say. Can we cure it? That is the great question. All manifestations of syphilitic disease, when advanced to a certain stage, are notorious for their incurability, and the

affections of the larynx are particularly so, for the reason that the parts can never be kept at rest. Consequently, diseases of this part are more fatal than any others.

The treatment of this affection is twofold—in the first place constitutional, and in the second place local. The constitutional treatment is that of syphilis in general. You have heard that treatment recapitulated in a few words in the notes of the case just read, viz., mild mercurials and the iodide of potassium. It may be proper for me here to make a remark in relation to the use of mercury in so-called tertiary syphilis. These symptoms of the disease so designated are undoubtedly in many cases best treated by mercury. But as to the mode of using the mercury, I have a word of advice to give. You must not rely upon the medicine alone to cure the disease; it must be given in such a manner as not to interfere with the nutrition of the individual, otherwise it does more harm than good. To this end mild mercurials, fumigations, inunctions, and the like are resorted to, that our patients may grow fat at the same time the disease is being cured. Syphilis is a curable disease, but we don't know when it is cured. The treatment must be chronic to cure a chronic disease; in some cases not giving up the persevering use of these milder mercurials inside of 18 months or 2 years. If patients die from this disease, it is either from neglecting themselves, or, which God forbid, by the neglect of the surgeon in attendance.

Fumigations by cinnabar is an old remedy, and were it not for the irritation that it produces in most cases it would be a very good one. I have substituted instead of this remedy the metallic mercury, calomel or black oxide. Each one of these, I think, possesses all the good qualities of the cinnabar, but without any of its unpleasant effects.

Finally, of what advantage is bronchotomy. The patient before us answers that question, I think, satisfactorily. It can assist you by enabling the patient to breathe without his larynx, by quieting that larynx so that your mercurial administration may cure the ulcers. In this way it will prevent the death of your patient by an interference with the functions of that vital organ. Suppose we had treated the case never so skillfully without that tube. What would have been the result? He is now so situated that we can treat him at our leisure. He may not be able to remove the tube even after the disease is entirely cured, inasmuch as it is possible that there may be some permanent obstructions higher up, the result of the contraction of cicatrices. It depends then upon the extent of the lesions in this man's larynx whether he shall be able to dispense with the tube or not.

We ascertain if the larynx is permeable to air by directing him to place his finger over the mouth of the canula for a few minutes at a time. The next step is to insert a cork into the tube; let it remain at first half an hour at a time, and cautiously extend the time to 3 or 4 hours; and finally when he can tolerate its presence for 24 hours at a time, the whole instrument can be removed with a good deal of certainty that no unpleasant results will follow. As bearing particularly upon this point, I cannot resist the temptation to refer to a case of membranous croup in a child 3 years old, in which I have very recently performed the operation of tracheotomy, as a last resort to prevent suffocation. Subsequently to the operation the disease did not extend, as it is so apt to do, into the bronchi, consequently the child recovered. One week after the operation the cork was worn in the canula all day, and on the following day it was removed altogether, in 3 or 4 hours after which the opening closed so as to compel the air during respiration to escape by the natural passage.

This, gentlemen, is all I have to say in relation to syphilitic laryngitis, and if I have succeeded in so interesting you in this subject that you are led to study the disease, I shall have accomplished my object.

## Original Communications.

### FISTULOUS ULCER IN FRONT OF THE LARYNX.

BY JOHN WATSON, M.D.,

SURGEON TO THE NEW YORK HOSPITAL.

THE facts connected with the two following cases, relate to a local ailment not often recognised by surgical writers; an ailment apt to be misunderstood, and one which, even when properly recognised, has hitherto not usually been found amenable to treatment.

*Case First.*—On the 6th of April, 1838, I saw in consultation with a gentleman of considerable surgical experience, a young lady, Miss C., about twenty years of age, who for the previous two or three years had been troubled with a papillary ulcer in front of her neck immediately over the thyroid cartilage, and from the centre of which there had been a continual weeping of a glutinous transparent colorless fluid, like inspissated synovia. Several attempts had been made by the gentleman in attendance, and by others, to close this ulcer, but without effect. Milder means proving of no avail, the ulcerated integument had been excised, under the hope that a newly exposed surface in the healthy skin might take on the process of cicatrization. But after the wound had contracted to a small point, the glutinous discharge, which had not been arrested, continued to keep the parts from closing. Again a second and more severe operation had been undertaken, in which the integuments for a wide space around the ulcer were excised, and the edges of the wound were drawn together by suture, so as to favor union by the adhesive process. The only effect of this measure was to leave an unsightly transverse cicatrix, which greatly disfigured the exposed surface. When I first saw the patient, the ulcerated opening in the centre of this cicatrix was hardly large enough to admit the point of a delicate probe. But after penetrating through the orifice, the instrument slipped readily onwards for about an inch under the integuments, in the median line, upwards in front of the thyro-hyoid ligament, to the border of the os hyoides, where it rested. On withdrawing the probe and grasping the parts along which it had passed, I could feel beneath the skin a delicate cord-like track of induration, such as might result from the indurated parietes of a narrow fistula.

After some deliberation, seeing that the true character of the case had not hitherto been appreciated, and bearing in remembrance that I had often cured obstinate fistulae in other parts of the body by injecting them with corrosive sublimate, I advised the gentleman in attendance, first, to inject the fistulous track with pure water, so as to cleanse it, and then to throw in, through a delicate canula introduced to the bottom of the fistula, as much as the parts would contain of the following solution:

R. Muriatis Hydrargyri  
Muriatis Ammoniacae, aa gra. v.  
Aque pure ʒi.

M.

It is sufficient to add that a single application of this solution arrested the glutinous discharge, and led in a few days to the permanent cure of the fistula. I last heard from this young lady on the 1st of July, 1839. There had been no return of the disease, her health was good, and she was then preparing for her approaching marriage.

*Case Second.*—On the 17th of May, 1859, Mary Kelly, aged 17, entered the N. Y. Hospital, with a minute ulcer in front of her neck, over the thyroid cartilage, giving issue to a glutinous discharge corresponding in all respects with that observed in the previous case, and surrounded by a rugged and irregular cicatrix about an inch wide, the result of escharotic applications that had, among other



means of treatment, been employed to no purpose. The discharge in this was more glutinous than in the former case, and when not frequently washed off, would form a thick crust over the ulcerated surface. The fistulous track would not admit an ordinary probe. I was obliged to employ a delicate gold probe intended for the puncta lachrymalia, in order to enter it. But the instrument, as in the other case, after passing the orifice, readily reached the anterior border of the os hyoides, passing in as before, through a track in the median line, somewhat over an inch in length, and the parts here, when grasped, giving the same feeling of cord-like induration.

After dilating the fistula by the use of probes of various sizes, the same course of treatment was employed as in the other case. The house-surgeon, however, mistaking my directions, at first employed a solution of only two grains of corrosive sublimate to the ounce of water. With this he injected the fistula several times with no apparent benefit. But on increasing the strength of the solution to four grains, a single injection arrested the oozing, and in the course of a few days effected a permanent cure of the fistula.

While recording these facts, I have some obscure recollection of an earlier case of the same ailment, the particulars of which I cannot now recall. I have since heard of a recent instance of the same sort, in which the gentleman in charge had been baffled in his efforts to effect a cure. And on mentioning these circumstances to my friend, Dr. A. H. Stevens, he remarked, that they reminded him of similar cases which, many years ago, had given him much embarrassment.

The rationale of these cases would seem to be, that the first point of diseased action is in some minute bursa, or cyst, near the anterior border of the os hyoides, and that the fistula is first established, and afterwards kept patulous, by the glutinous discharge secreted there.

I have not attempted a minute inquiry into the history of this ailment, as given by the surgical writers of England or our own country; but in the few of their works to which I have referred, I have found little or nothing satisfactory. So far as I am aware at present, we owe the first allusion to this disease to Boyer, who appears to have met with two cases of it, which he treated unsuccessfully by the knife and escharotics. He speaks of it as an encysted tumor forming between the os hyoides and the thyroid cartilage, containing a viscid yellowish fluid, and subsisting a long time without acquiring any considerable size, or causing any embarrassment, but disfiguring the neck, especially of females. [*Maladies Chirurgicales*, tome vii., p. 39; Paris, 1834.] In the *Eléments de Pathologie Chirurgicale*, prepared under the supervision of M. Nélaton, vol. 3me, p. 383, I find an allusion to the same ailment, apparently derived from Boyer, but with some additional details derived from the researches of Bèclard and M. Malgaigne, especially in reference to the normal existence of two bursæ in the locality occupied by this fistula; the one, over the projection of the thyroid cartilage; the other, somewhat above this, in the thyro-hyoidean space. The writer in question is disposed to believe that the source of the glutinous discharge is some mucous follicle near the base of the tongue, founding this opinion on what he assumes to be the fact, that the discharge is rather of a mucous than of a serous character. The truth, however, is, that the discharge is such as we often meet with in openings communicating with the joints, and such as I have often seen issuing from diseased bursæ. He speaks of treating the disease by iodine injections.

Dr. Gross, in his recent systematic work, while treating of injuries and diseases of the neck, alludes to what he calls the "*Synovial Bursa*," in the following words: "An encysted tumor sometimes forms in the upper and fore part of the neck, taking its rise in the synovial sack situated between the hyoid bone and the notch of the thyroid cartilage. This sac, which, in its natural state is hardly a few lines in diameter, may, in consequence of inflammation,

acquire the volume of an egg, if not of a small orange. It is of oblong shape, elastic, slightly translucent, and filled with a thin, serous, oily, or viscid fluid. The superincumbent skin is healthy, and the swelling is entirely free from pain. The treatment is by seton, injection, or incision, as in encysted tumors in other parts of the body." [*System of Surgery*, vol. ii. p. 545.]

Tumors such as are here described, I have myself occasionally met with. I have not considered them pathologically identical with the disease giving rise to the fistulous ulcer. But whether both may or may not be looked upon as different phases of the same malady, I will not at present undertake to determine.

NEW YORK, May 25th, 1860.

## ANÆSTHESIA AND ANÆSTHETICS.

BY EDWARD R. SQUIBB, M.D.,

OF BROOKLYN, N. Y.

THE condition of insensibility to pain belongs exclusively to the brain proper, or to that part of the nervous system which provides for sensation and voluntary motion; and is effected, when not the result of mechanical injury, invariably through the agency of the circulation. It therefore follows upon this, and upon the circumstance that the nervous centres of organic life exercise no primary function of ordinary sensation or voluntary motion, that the special agents resorted to for anæsthetic purposes should not only be directed especially to the sensorium, but should be diverted as far as practicable from the remaining portions of the nervous system, in effect. But, the circulation carries the anæsthetic agent everywhere, and with the elements of vitality and molecular reproduction must convey and distribute this powerful agency also; and hence the special agent for effecting anæsthesia should not only act directly, promptly, and transiently upon the sensorium, but should be, as far as possible at least, innocuous elsewhere. In short, it should suspend the functions of the sensorium without liability to interference with any other organ or function.

Such an anæsthetic effect is produced perhaps in the greatest degree of perfection by a certain amount of concussion of the brain, which sometimes results from accidental violence; and the effect is most perfect here, because it is produced directly upon the brain without any contamination of the circulation with foreign influences; and the circulation thus left free for the performance of its normal functions not only preserves the organic life intact during the temporary abstraction of the presiding sensorial functions, but through its reparative agency quickly remedies the shock, and restores the brain to its normal condition.

The next most perfect anæsthetic effect is that to which a small proportion of persons are susceptible, wherein the sensibility to ordinary impressions of pain or injury is suspended or overpowered through concentric nervous effect. Whenever the balance of nervous power is so disturbed as to reverse the current of the nervous batteries (so to speak), as in the so-called mesmeric condition of certain persons of feeble nervous tone or energy; and in the high degree of nervous excitement to which others are liable through agencies that act altogether from without, the æsthetic functions of the sensorium are altogether suspended, as in catalepsy, or are so impaired that serious injuries are unconsciously received.

The effect, however, in both these classes of cases can never be utilized if from no other cause than because it is independent of the circulation, and all other practical means of production, maintenance, and control. The circulation therefore becomes indispensable as the means of introducing the anæsthetic agent, and of controlling its effect; and the collateral circumstance that the circulation must inevitably carry the agent to parts where it is not

desired, and where it may become noxious, must be taken as a drawback, and, a most important indication in both the selection and management of the anæsthetic to be used.

From these circumstances, and inductions taken as points of departure, it is not difficult to deduce the indications in the use of anæsthetics as being, first, to suspend sensation and voluntary motion; and, secondly, to do this with the least possible interference with the functions of organic life. These points admitted, and kept prominently in view, will, with a little reasoning, render the management of anæsthetic agents very simple, and will make the accidents and mismanagements more intelligible and more easily avoided.

These accidents are, first in importance as well as in frequency perhaps, some form or degree of asphyxia. All the vapors used for anæsthetic purposes are irrespirable. That is, they do not contain oxygen in a condition in which it is available in the lungs for renewal of the blood. Just in proportion, therefore, as the vapor is introduced is the normal quantity of air diminished, and the proper oxidation of the blood prevented; and the ratio of this proportion is as inevitable in the effect upon the powers of life as it would be if carbonic acid or water, or any other irrespirable medium was substituted even up to that proportion which produces spasmodic closure of the glottis. It has been not unfrequently noticed, in what the writer believes to be the mismanagement of both the common anæsthetics, that the administration has commenced with a proportion of the vapor so large as to produce this spasmodic closure of the glottis. Under such circumstances, if it was possible to keep up such a proportion throughout the struggling of the patient, the spasmodic closure would doubtless be as persistent as it is in drowning. But when from withdrawing the sponge a little, or from the displacement of it in struggling, the proportion of air is increased, the glottis is relaxed again, and the imperfect respiration goes on quickly to a point when, from the undue, sudden, and depressing effect of the anæsthetic on the nervous centres, the glottis no longer responds to the action of the irritant, and the vapor passes freely into the lungs, no matter how strong or how small the proportion of air mixed with it. The pulse and respiration then give the indications to suspend and reapply the anæsthetic, and it becomes a matter of time, endurance, and of management as to how far the powers of life are taxed.

It is, therefore, not a question as to whether aeration of the blood is to be interfered with at all, or not, since some portion of anæsthetic vapor is indispensable, and since that portion must exclude a corresponding portion of the air; but the question is rather, how far the due aeration of the blood may be judiciously and safely interfered with;—or in other words, what degree of asphyxia is justifiable and proper in the management of anæsthetics; and the natural conclusion is as practical as it is logical, namely, that the least possible degree is safest and best, and that the interference should not be hurriedly induced, nor maintained a moment longer than is absolutely necessary.

If suspended animation from the circulation of venous blood in the brain was to be resorted to for anæsthesia, it would be necessary to immerse the patient at intervals in water, carbonic acid, or other irrespirable medium, in order to maintain the condition; and the risk of fatal asphyxia would be here much more apparent, though really not very much more imminent than in the nearly parallel case wherein the irrespirable vapor of ether is substituted throughout a clinical lecture, with the antagonistic stimulant effect of the operation postponed till near the end of a long period of insensibility. The position that the insensibility in *ordinary* anæsthesia is due to the circulation of unrenewed blood in the brain is, however, only true in part at the utmost, and this introduces another of the accidents that may occur in the management of anæsthetics.

If it were possible to separate the true desirable anæsthetic effect from every vestige of asphyxia on the one

hand, and from all direct interference with the functions of organic life on the other, it would probably be found to consist in a simple specific paralysis of the nervous ganglia of sensation; and the desirable degree of such effect would be that which did not at all overreach the object. By overreaching the object however, whether it be by a too profuse, or a too prolonged use of the agent, the result must be injurious, since suspended function is but one step in the catenation which leads to disorganization and death,—and that step once passed the others may be accomplished insidiously. Such an hypothetical position is, however, only assumed to show that there must be a condition of hyperanæsthesia, or excessive anæsthetic effect,—that such a condition is hurtful and unsafe, and that it should be avoided by skill in management, no matter how safe the agent used may be considered.

That such conditions do not occur without warning through the failing functions of organic life, is the fortunate result of the harmony and dependent action of the nervous centres, and these functions of organic life are commonly and very properly watched, as the means of control in the administration of anæsthetics. But apart from the fact that a most hurtful and dangerous degree of asphyxia may be induced suddenly, and while both pulse and respiration are spasmodically kept up by the stimulus of the first effect of the agent used, there are grave accidents which occur to the centres of organic life, both by reflex action from the brain proper, and by the presence in the circulation of such powerful depressing agents. Blood overcharged with anæsthetic vapors, and particularly when imperfectly aerated and slowly circulated, must necessarily fail of its due impression upon the cardiac and respiratory ganglia, and paralysis of the heart, or muscles of respiration are, therefore, the common fatal accidents of anæsthetic practice.

All these circumstances lead directly to the conclusions, first, that anæsthetics should be given slowly and carefully, with free, unlimited admixture of air, so that there should never be any choking or spasmodic action of the glottis. Secondly, that they should only be given at the time when the effect is needed, and be abandoned the moment the necessity is past. Thirdly, that not only should the pulse and respiration be watched carefully during the whole period of insensibility, and be kept as near the normal standard as possible, but the slightest amount of blueness or lividity should be regarded as an indication of asphyxia, and be promptly responded to by a more free admission of air.

In the choice between the two anæsthetics in common use one or two points are deserving of attention.

Chloroform is much less liable to produce cyanosis or asphyxia, because it is effective in much smaller quantity than ether, and does not therefore displace so much air in the respiratory process. The writer has never noticed any degree of blueness from the use of chloroform, but has often seen it in the use of ether. On the other hand, unless chloroform be given with far more care than is necessary with ether, it is, from its greater efficiency, much more liable to produce hyperanæsthesia, and to paralyse the heart and respiratory muscles. Hence chloroform, under ordinary circumstances, must be considered more dangerous to life, because its greater efficiency and activity, while they render it less liable to produce asphyxia, render it more liable to produce the other accidents of anæsthetic practice. The balance against it is, however, more applicable to its common and indiscriminate use, than when applied with the care and precaution indicated in the foregoing remarks; and there is probably quite a large class of cases in which it cannot judiciously be replaced by any other agent, as, for instance, in parturition; in uremic convulsions of gestation and parturition; and, in short, whenever an intermittent and prompt effect are desirable, and the due precautions can be rigidly observed. In careful practice, with ordinary good judgment and observation, it has in the writer's opinion, the advantage over ether in

every point except the single important one that, in rare instances, it is liable to produce sudden fatal paralysis of the heart.

Ether has been regarded as so safe an anæsthetic, that it is scarcely admitted as susceptible of doing harm; and the impression is very common that it can never endanger life. That either of these propositions can be accepted admits of great doubt.

In the asphyxia from drowning, if the immersion be of short duration, and if the muscular system has not lost its vital tonicity, it is usually only necessary to re-establish the respiration and circulation for a short time, by artificial means, to restore life. If that drowning be prolonged, however, by repeated short immersions, so that the same inefficient condition of the circulating blood be brought about during a half or three quarters of an hour of struggling, and with depressing influences from other sources, as of previous disease or injury, so that the powers of endurance are worn out, and passive exudations are permitted to accumulate and obstruct the pulmonary air cells, the result would probably be very different. A condition of vital depression would be established which might very slowly go either way in the balance between life and death, but which would probably, in case of other coinciding influences, as after a serious surgical operation, ultimately terminate fatally. The partial asphyxia produced by a prolonged etherization is a nearly parallel case under ordinary circumstances; and here, as in other instances, pernicious influences may be masked by the complication and remoteness of the results.

So strongly has the writer's attention been drawn to these circumstances, by seeing and hearing of the profuse and wasteful use of ether, that it is a prominent object of this article to invite the profession to a closer scrutiny and observation of the effects; and if two or three fluid ounces of ether be found to produce a safer and better effect than double that quantity, an important point will have been attained.

The method of administering ether adopted by some close observers is one which appears well adapted to ensure a due admixture of air. A folded napkin is rolled into the form of a cylinder, or truncated cone, and secured at the overlapping edges by two pins. The larger end is made wide enough to cover the nose and mouth, the nose fitting into a notch, where the two edges of the napkin at the widest end fail to overlap. The opening at the small end should be at least one and a half inches in diameter, and the larger the better. If anything be needed to give stiffness and form to this cone, a piece of pasteboard laid between the folds of the napkin before it is rolled up, will accomplish this purpose. This cone is held in the hand of the person who gives the ether, and as a matter of economy it may be removed from the face during each expiration. About two fluidrachms of ether is poured upon the inside of the napkin at a time, and renewed as often as may be requisite.

In the administration of ether for anæsthetic purposes, at least three well-marked stages are commonly observable, and the duration of each varies very much with the temperament of the individual, the condition of the stomach, and the quality of the ether used. One of these stages, namely, that of excitement and delirium, and the only troublesome one, has been hitherto supposed to be shorter in proportion as the ether contained less alcohol; but some very recent observations made by the intelligent House-Surgeon of the New York Hospital, Dr. Weir—though as yet very limited in number—would appear to indicate that the point of maximum, or best effect in this respect, may be overreached, or that a determinate small proportion of alcohol in the ether may be useful. At least, Dr. Weir has been very naturally led to this inference by the effect of giving a small amount of brandy before the anæsthetic; and subsequently by the use of alcoholic ether. He, however, states distinctly, that as yet his observations are not sufficiently numerous to be relied upon. An occasional

accident in the prolonged use of ether, for the mention of which the writer is also indebted to Dr. Weir, is the occasional occurrence of a smart, ephemeral, irritative fever, which follows within twenty-four hours. In view of the circumstance that the local effect of ether is irritant to the extent of producing vesication when confined upon delicate surfaces, it may be easily understood that its application over the large and delicate mucous lining of the bronchial ramifications, throughout an unusually tedious and difficult operation, might produce a transient inflammatory effect. In conclusion, the writer is aware that the character and drift of these remarks are directly at variance with the teachings of some very high authorities, who regard the anæsthetic condition as one of dead-drunkness, and who advise the rapid and copious administration of the ether, in order to reach this condition in the shortest possible time.

It appears to the writer singular, that those who are in the daily habit of making the most delicate distinctions in diagnosis, should fail to discriminate between the effects of poisonous doses of alcohol and the desirable condition in ordinary anæsthesia, since they certainly do not much more nearly resemble each other than the coma of narcotism resembles natural sleep.

BROOKLYN, May 28th, 1860.

#### A CASE OF STONE IN THE BLADDER—HIGH OPERATION—UNSUCCESSFUL RESULT.

BY JAMES R. WOOD, M.D.,

SURGEON TO BELLEVUE HOSPITAL.

THE high or supra-pubic operation for calculus of the bladder is not often practised at the present time, and it is rare that any surgeon selects it in preference to the lateral method. In certain cases, however, it is still preferred by many surgeons as in lithotomy in the female, and in children, while in some cases, as where the stone is very large, the prostate greatly enlarged, or other peculiarity renders the lateral operation difficult or impossible, the supra-pubic method must necessarily be adopted.

In the following case the high operation was decided upon after consultation with my colleagues on account of the existence of a greatly enlarged prostate, and the remains of an old stricture. The notes have been kindly copied from the Hospital Records, by Dr. Eugene Peugnet, house surgeon:

Ward 17, Male Bed 11.—David Gibson, æt. 58: Ireland; weaver; married; temperate in his habits; bad constitution. Admitted Feb. 20th, 1860. (Service of Dr. Jas. R. Wood.)—About four years since patient was treated, in private practice, for chronic cystitis and stricture of urethra. At that time there were two strictures distinctly perceived, one in the membranous portion, and the other in the prostatic portion of the urethra, directly behind the triangular ligament. There was also a false passage situated anterior to the first stricture. The prostate was very much enlarged, measuring about two inches laterally; a No. 5 sound being at that time passed with great difficulty. The urine, which was examined from time to time, contained abundance of triple phosphate, pus, and viscid mucus, together with albumen dependent on the blood. The patient occasionally passed small crystals of triple phosphate, which caused him a great deal of pain, particularly when passing the seats of the strictures. Patient had never contracted gonorrhœa, but in his early youth had been accustomed to ride a great deal upon horseback. At the date of admission his general health was poor. The strictures had been somewhat relieved, and a No. 10 sound could be passed with difficulty, though the patient had still considerable difficulty in urinating, the use of the catheter being frequently necessary. On further examination, a calculus was discovered in the bladder. The prostate measured about three inches laterally. The patient



complained of considerable pain in the small of his back. On analysis and microscopical examination of the urine, it was found to contain pus, mucus, and triple phosphate, together with albumen and blood.

April 7th, 2 P.M.—Patient was put under the influence of an anæsthetic with difficulty, by Dr. J. J. Crane, there being a remarkable muscular rigidity, and the bladder having been injected with  $\frac{3}{4}$  xiv. of tepid water. Dr. Jas. R. Wood, assisted by Drs. Parker, Buck, and C. T. H. Meier, proceeded to perform the high operation for stone. The Doctor first made an incision three inches in length just above the pubes, in the median line, successively dividing the abdominal layers, down to the bladder, and going through the linea alba. The organ being very readily exposed, it was seized with a double hook and drawn downwards by Dr. Meier, the lips of the wound being separated and the peritoneum held back by Dr. Parker. Dr. Wood then cut into the bladder and introduced his finger in order to ascertain the position of the stone, and then extracted it from the bas-fond of the bladder with a small pair of calculus forceps. The stone was about the size of a pigeon's egg. At this stage of the operation a portion of small intestine protruded. They were returned without difficulty. The ruptured peritoneum, together with the transversalis fascia, which was loaded with fat, was secured by two silver sutures, and the wound in the bladder by two more. The external wound was closed and the edges held in apposition by two more silver wires, a compress of lint laid over the wound, and a flexible catheter was then introduced into the bladder and held in its position by tapes. Two grains of opium were then administered and ordered to be repeated every hour with brandy  $\frac{3}{4}$  ss.

4.30 P.M.—Pulse 104. Complains of cold and a good deal of pain and tenderness over the abdomen. Ordered bottles of hot water to be applied to thighs and sides of the patient.

6 P.M.—Pulse 104. Patient feels rather more comfortable.

7 P.M.—Ordered carb. ammoniæ, gr.v., and tr. capsici, gtt. xv. every half hour.

8.30 P.M.—Pulse 122, and rallying; skin warm; respirations 24; pupil moderately contracted; tongue moist; thirst; considerable pain; urine passing freely through the catheter.

11 P.M.—Pulse 120; respirations 24; skin warm and moist; tongue coated white; pupil contracted somewhat; a good deal of pain and tenderness; thirst.

April 8th, 4.30 A.M.—Pulse 100; respirations 24; tympanitis well marked; slight pain.

9.30 A.M.—Pulse 133; respirations 36; pupil not so much contracted; considerable tympanitis. Ordered opium gr. ij. every half hour. (The opium taken by the patient up to this time was made into 1 gr. pills instead of 2 grs., owing to a mistake of the apothecary, which is now rectified.)

1 P.M.—Pulse 120; respirations 24; patient is somewhat narcotized; extremities cold.

4.30 P.M.—Pulse 100, and weak; respirations 32; patient is rapidly sinking.

9 P.M.—Patient is unable to swallow his medicines; extremities cold.

April 9th, 3.30 A.M.—Died.

*Autopsy eleven hours after death.*—Rigor mortis well marked; considerable tympanitis. On opening the abdomen slight evidences of peritonitis were found, and some old adhesions between the small intestine and cæcum. A rupture of the peritoneum was found at its reflexion from off the bladder. Two silver sutures had been passed through the peritoneum, which was found to be united. Another and transverse wound of the peritoneum was found at the point where it is reflected on to the abdominal wall, the small intestines having protruded through the larger opening; the bladder was found firmly contracted; there was no extravasation of urine. The coats of the bladder were very much thickened and softened. The kidneys were very much diseased; the right one containing some cysts. Upon opening the left kidney, which weighed

about fourteen ounces, a large abscess was found in its lower portion communicating with the pelvis, and containing an ounce of pus. Within the cavity of the abscess was found a large calculus of triple phosphate. Several small calculi were also found in other portions of the same kidney. The liver was healthy. A few obsolete tubercles were found at the apex of the left lung. The right lung and heart healthy. The prostate measured about three and a half inches, the middle lobe being much enlarged, about the size of the first joint of the thumb, and ulcerated; two false passages in the membranous and prostatic portion on either side of the stricture.

The high operation has at different periods had its special advocates, and has by them been performed exclusively in a sufficient number of cases to give some valuable statistics. We can refer to the following: Maund lost five in forty operations; Côme, nineteen in one hundred; Cheselden, one in seven; Souberbille, eleven in thirty-nine. Mr. Humphrey in a statistical article (*Trans. Provincial Med. and Surg. Assoc.*, vol. 17.) has collected one hundred and four cases, of which thirty-one were fatal, or less than one in three. The following table of the comparative results of the different methods of lithotomy from Dr. Gross's recent excellent work on surgery is very instructive:

Methods.	Cases.	Cures.	Deaths.	Proportion.
Lateral operation,	5418	4824	589	1 in 9 $\frac{1}{2}$
Bilateral method,	207	175	32	1 in 6 $\frac{1}{2}$
Recto-vesical section,	83	67	16	1 in 5 $\frac{1}{8}$
Supra-pubic operation,	180	141	39	1 in 4 $\frac{1}{3}$

The supra-pubic operation has now been performed in this city at least ten times, and with results much less favorable even than are given in the above table. By the courtesy of the several gentlemen who have performed this operation, I am permitted to append to my own case brief notices of their cases.

**OPERATIONS BY DR. PARKER.**—*Case 1.*—Mrs. L. æt. 53, married. The stone was large; operation commenced by injecting the bladder with warm water; incision above the pubes, two and a half inches along the linea alba, cutting down to the bladder; opened the bladder with a pointed bistoury, which was followed by such a regurgitation of fluid through the artificial passage, that the assistant was directed to remove his finger from the urethra, and allow the contents of the bladder to escape; introduced the *bresepierre* of Baron Heurteloupe through the urethra; raised the fundus towards the external opening, until I was able to reach it with the tenaculum; incision not being sufficiently free, was enlarged; the finger being introduced, the forceps were readily carried into the bladder, and the stone removed with great ease; operation terminated by closing the upper portion of wound, and leaving lower part open to admit the free escape of urine, or pus, and thus prevent infiltration; patient recovered very rapidly; stone nearly two inches in length, and one and a half in breadth.

*Case 2.*—Miss M., æt. 53, had a large urinary calculus; made trial of lithotripsy; succeeded in breaking off about one drachm; bladder became inflamed, and in about three weeks proceeded to remove the stone by the high operation; patient was put under chloroform; bladder injected with flaxseed-tea; made an incision along the linea alba, and reached the bladder readily; hooked strongly through it by large tenacula, then punctured the bladder with a pointed bistoury, and made an incision about and a half inch in length; easily removed the stone with nasal polypus forceps; upper part of wound was closed with a suture, the lower being left open for the escape of any discharge; result very satisfactory.

*Case 3.*—Mrs. E., æt. 47, had suffered from stone in the bladder, until she could hardly move about; operated according to the plan laid down in the preceding case, and notwithstanding the amount of disease of the bladder, pa-

tient improved greatly, and three months after was comfortable, but had a slight opening above the pubes, from which pus, at times, escaped.

*Case 4.*—A. W., æt. 53, Sing-Sing, symptoms stone in the bladder. Patient, a lawyer, with great nervous development; his system had been greatly overworked in the practice of his profession; had difficulty about the urinary organs for some five years; urine containing pus, blood, and triple phosphate; an examination with a sound revealed the presence of a stone in the bladder; calculus appeared to be encysted; it was removed by the high operation, Dec. 17, 1857. Patient rallied from the effects of the operation, but in 36 hrs. began to vomit, sank gradually, and died Dec. 21 (four days after the operation), from violent, and long continued emesis, caused by inflammation and softening of the stomach, as the autopsy showed. The external wound had healed, no urine came through it, but all flowed by drops from a catheter placed in the bladder after the operation.

*OPERATION BY E. NOEGGERATH, M. D.—Case.*—S. B., a healthy child until the age of three, when his parents noticed a change in his generally lively disposition; complained of fatigue in the limbs; wet his bed at night, and even his clothes during the day; several physicians pronounced the disease catarrh in the bladder. When called to the case, child was eight years old, and pitiful to behold; his body reduced to skin and bone, with an expression in his face of long continued and intense suffering. He was constantly wetting his clothes with urine, and supporting his perineum and scrotum with his right hand. This last phenomenon determined me to make an instrumental examination of the bladder, although the skillful physicians who had, in their examination, found no stone, almost satisfied me that there was really no calculus present; after repeated trials, a stone was detected; the high operation was performed in the usual manner, and a very large calculus removed with great difficulty; the boy recovered after suffering from prostatic calculi.

*OPERATIONS BY DR. KRACKOWITZ.*—*Case 1.*—John Nelson, born of healthy parents, July 10, 1857. While a baby a few weeks old, had varioloid; since then, has been often sick with diarrhoea and bronchitis. About the middle of February, 1859, had symptoms of stone in the bladder; in May, masses, like mortar in consistence and color, passed from the urethra. At that time the parents brought him to the German Dispensary, of the City of New York, (132 Canal street,) to be treated for catarrhal pneumonia. When he got better of that, under the care of Dr. M. Herzog, he was turned over to the surgeons to be examined for stone. Dr. L. A. Voss found the entrance to urethra blocked up by a substance which, after dilatation of the opening of the urethra, had a cylindrical shape, being about half an inch long, forming a cast of the urethra, of whitish color, resembling mortar. An examination made May 16, with the sound, revealed, without difficulty, a stone in the bladder. All symptoms of pneumonia having subsided, the operation was performed May 22, 1860. The sensation imparted to the touch by gently squeezing the stone, could be compared to nothing better than that of a hard-boiled egg. The patient went on the first three days satisfactorily, but pneumonia set in of which he died.

*Case 2.*—R. C., 18 months old; has suffered from symptoms of stone in the bladder from birth; operation Nov. 19, 1859; closed wound of the bladder with the silver wire sutures; great prostration and vomiting from chloroform; rallied after four hours, but grew weaker in the night, and died ten hours after operation.

*Case 3.*—D. E. Symptoms of stone three years; operation after same method; Dr. Sims applied the silver suture; did well for six hours, then tenderness and swelling of the abdomen; vomiting; great restlessness; rapid, small pulse; died twenty-three hours after operation.

*OPERATION BY HENRY STUART HEWIT, M.D., FORMERLY OF THE U. S. ARMY.—Case.*—E. S., aged 19; all the rational signs of stone in the bladder; after mature deliberation, determined to select the high operation; ordinary abdominal section was made; the viscus raised upon the point of the retained catheter was secured by a stout suture passed through its coats; the stone was extracted with the utmost ease; the incision in the bladder was immediately closed by four points of interrupted silk suture, inserted with the aid of a sharp artery-needle; patient made a rapid recovery.

## Reports of Hospitals.

### NEW YORK HOSPITAL.

#### AMPUTATION OF LOWER THIRD OF FOREARM, ACUPRESSURE.

[Reported by ROBERT F. WEIR, M.D., Resident Surgeon.]

THE patient on whom Simpson's method of controlling hemorrhage by acupressure, was first practised in the New York Hospital, was a healthy young man, aged 23 years, who had received a short time prior to his admission (March 16th, 1860,) a severe compound fracture of the left metacarpus with considerable laceration of the soft parts, which had been produced by his becoming caught in some machinery. An attempt was made to save the ulnar portion of the hand, where was the least amount of injury, but this, however, failed, the fingers sphacelating. The wound was then left to digest, and attention was directed towards improving his general condition in reference to a secondary amputation, which was performed, April 26th, by Dr. Van Buren, at the junction of the lower and middle thirds of the forearm; the tissues of which were much thickened and cedematous. The method of anterior and posterior flaps of integument with circular division of muscles, etc., by successive incisions, was adopted; the tendons also were drawn out of their sheaths to a moderate extent, and cut off to prevent interference with primary union, in the manner advised by Mr. H. Crokery in *Med. Times and Gazette*, vol. i., 1860, p. 86. Three common Berlin wire wove pins, about two and a half inches in length, and similar to shawl pins, were used; one each, for the radial, ulnar, and interosseous arteries, the latter being secured by a needle passed directly through the interosseous space, but not appearing in the face of the stump, and compressing the vessel against the outer border of the radius; the other arteries being secured. The extremities of each needle being in the cutaneous surface of the palmar flap as the stem of a flower is fastened to the lapel of a coat. No ligatures were applied, and the stump was closed by seven silver wire sutures; some slight oozing occurred the same evening from the outer angle of the wound but ceased spontaneously. Forty-eight hours after the operation, but moderate swelling having ensued, the needles were carefully withdrawn, and on the eighth day the sutures were also removed; union by first intention having taken place throughout the deeper portions of the stump, and but a slight linear ulceration being visible at its periphery. This speedily cicatrized, and the patient was discharged from the hospital May 19th.

#### INCISED WOUND OF WRIST—RADIAL AND ULNAR ARTERIES SEVERED.

[Reported by T. B. WARD, M.D., Acting Resident Surgeon.]

I. S., ætat. 37, was admitted April 2d, having received among other injuries in a fight, an incised transverse wound of the left wrist, dividing the radial and ulnar arteries. When first seen by the surgeon he was suffering from the effects of the hemorrhage, which, according to all accounts, was quite profuse immediately after the injury was inflicted. The wound was cleared of clots, both vessels were secured at their proximal and distal extremities, and the lips brought

together loosely in order to court union by second intention, and the whole supported by a dorsal splint on the forearm.

The process of cure was a very tedious one, the granulations for a long time were pale and indolent. This circumstance was no doubt owing to the anemic condition of the patient, but more particularly to the imperfect establishment of the collateral circulation of the parts.

#### PENETRATING WOUND OF CHEST.

James Fleming, æt 23, New York, was admitted April 29th, at five o'clock A.M., having received his wound in a bar-room scuffle, the instrument used being an oyster knife. The wound is three-quarters of an inch in length, and situated two inches to left of median line of sternum. The first rib is entirely divided across three-fourths of an inch from its sternal articulation. The lung is evidently penetrated, from the fact that air issues freely from the wound. Slight oozing of venous blood at time of admission. Patient is much prostrated, no pulse at wrist, surface very cold, jactitation of limbs, anxious countenance, &c.

*Treatment.*—The heater was applied, reaction was established, and afterwards opiates were administered, but at the end of the second day after, the patient was seized with the symptoms of pleurisy, which terminated in death the following day.

*Autopsy.*—Eighteen hours after death the catheter was introduced into the wound and penetrated to a depth of three inches in the substance of the lung. The pleural cavity was found to contain three and a half pints of serum mixed with blood. The left lung entirely collapsed, and wound found two and a half inches below apex. Strong adhesions around wound; other organs healthy.

#### BELLEVUE HOSPITAL.

##### MALPOSITION OF FÆTUS DETECTED BY EXTERNAL MANIPULATION DURING LABOR.—CEPHALIC VERSION BY THE SAME MEANS, —SUCCESSFUL.

The following interesting and highly practical questions in obstetrical science, have recently been agitated among those devoted to that branch of medicine. 1. Can a mal-position of the fœtus in utero be detected by external manipulation prior to labor? and, 2. Can such mal-position be rectified prior to labor by external manipulation? Some of the leading professors of obstetrics in this country have taken strong grounds in the negative, and several not only denying the possibility of detecting and correcting mal-positions prior to labor, but even questioning the professional honesty of the practitioner who should endeavor to determine by external examination, prior to labor, whether a mal-position existed. The following case, which occurred in Bellevue Hospital, a few days since, under the care of Dr. Barker, is a most important contribution to this subject. We copy the notes of the case, furnished us by Dr. E. B. Barrett, House Physician:

Mary Ann —, æt. 17, born in Ireland, was admitted to the Waiting wards of the Bellevue Hospital March 19th, 1860, in her first pregnancy. On examination, the uterine tumor was very conical, projecting markedly to the right, as well as forwards, triangular in shape, with its transverse diameter greatest. The os uteri was dilated to the size of a quarter of a dollar, and dilatable. The membranes were very full, and projected strongly from the os, and so tense were they that no part of the child could be felt from danger of rupturing them. On the following morning, as the pains had somewhat exhausted the patient from their teasing character, and as little or no progress was being made, an opiate was administered, from which the patient was enabled to obtain some sleep, awaking much refreshed at 12 M. (the 4th.) The pains now increased in force and frequency, but with no result, save the further dilatation of the

os, which was now between two and three inches in diameter. On vaginal examination no part of the child could be felt without rupturing the membranes; by palpation the previous conjecture, viz. that a transverse presentation existed, was rendered nearly certain.

Dr. Barker came to pay his daily visit at this juncture, and concurring in the opinion that the child presented transversely, decided on immediate interference. Accordingly the patient was brought under the influence of chloroform. Dr. Barker again examined the tumor more carefully, both by palpation and "per vaginam." Through the external walls the head could be felt in the left iliac fossa, above the pubis. The pelvic extremity of the fœtus was in the right iliac fossa, and the curve of the dorsum could be traced strongly projecting forwards. By a vaginal examination the os was found dilated to the diameter of about three inches, soft and dilatable, with a very large and projecting bag of waters. The presenting part of the fœtus could not easily be felt through the bag of waters, and no force was used for fear of rupturing the membranes; but the deduction, from the external and vaginal examination, was, that the right shoulder was the presenting part at the superior strait. Dr. Barker therefore decided to attempt cephalic version, in preference to the ordinary method, and he at once proceeded to operate, in the presence of several members of the medical staff of the hospital. The patient being brought to the edge of the bed, in the approved position, he first manipulated by attempting to elevate the pelvis of the fœtus with his left hand, and to depress the head with the right, acting only when it was found that the uterus was not contracting. Finding that he had essentially changed the position of the fœtus, the right hand of an assistant was placed to make strong pressure over the left iliac fossa; he (Dr. B.) still elevating the pelvis of the fœtus with his left, introduced into the vagina two fingers of the right, and during the time of uterine contraction ruptured the membranes, when the waters escaped with great force and abundance. The head could now be felt in the superior strait in the left *occipito iliac* position. The administration of chloroform was now discontinued, in the hope that the uterus would complete the delivery unassisted. Slight pains, with little progress, followed for fifteen minutes, and as the foetal heart was beating somewhat feebly, it was deemed necessary to apply the forceps. The forceps being applied, a male child, weighing eight pounds, was extracted in a partially asphyxiated condition. Respiration was established in a short time, however, and it is now a perfectly healthy child. The placenta came away in five minutes, with no more than the usual amount of hemorrhage; the perineum was not lacerated, and the patient but little more prostrated than is usual after natural labor. The patient proceeded to a rapid convalescence, with no unfavorable symptom, notwithstanding the prevalence of an epidemic of puerperal fever in the Hospital at the time of her confinement.

In his clinical remarks upon the case, Dr. Barker contended that he had demonstrated beyond cavil—1. That a mal-position of the fœtus in utero can be detected by external manipulation during labor. Auscultation furnished but slight assistance, and the results of an internal examination were entirely negative. The important fact, however, worthy of special notice is, that the position of the fœtus could only be determined when the uterus was in a quiescent state. It follows, therefore, if the most favorable time for detecting the position of the fœtus is in the interval between contractions, that a mal-position can be made out by external manipulation prior to labor; and if the position can be discovered in the interval of the pains of labor, it can also be done one, or two, or even many days before labor. 2. This case demonstrates the possibility of performing version by external manipulation during labor, and, as version by the hand introduced into the uterus was attempted in the absence of pain, he thought this case equally proved that version by external manipulation is possible before labor. But to have the fœtus remain in its



new position it would be necessary to rupture the membranes and induce labor, in order to secure the engagement of the head in the pelvic cavity.

### NURSERY AND CHILD'S HOSPITAL.

#### TWO CASES OF PLEURO-PNEUMONIA WITH PULMONARY ABSCESES WITHOUT CORRESPONDING SYMPTOMS.

[Under the care of GEO. A. PETERS, M.D.]

**Case 1. J. M.**— was admitted May 19th, 1859, at the age of two months. He was very delicate at the time of admission, and had slight bronchitis; in the hands of a wet-nurse he began to improve, and continued to do so till the middle of July, when several attacks of diarrhoea occurred at intervals of three or four days; each lasting not more than twenty-four to thirty-six hours; from the occurrence of these he began to decline, boils made their appearance upon the back part of his head and neck, and there was considerable constitutional disturbance; he was treated with tonics, vegetable and ferruginous, but they were of no sensible benefit, either as regards the eruption or the general condition of the child.

Aug. 1st. Continues to fail, with no apparent cause, except the furuncular eruption and the attacks of diarrhoea.

Aug. 5th. Died suddenly to-day of asphyxia, although he had had no symptom to direct attention to the chest.

**Autopsy—eight hours after death.**—Great emaciation; rigor-mortis; on opening the chest, the right lung was found collapsed, occupying a very small space; it could not be inflated, except in a few places in the lower lobe, which appeared to be pneumonic, having the solid feel belonging to this disease; from one to two ounces of turbid serum, were found in the pleural cavity; both the parietal and pulmonary pleurae were pretty well covered with a fibrinous deposit of a creamy appearance. Some of this had settled in the depending portion of the cavity. On the left side the lung also occupied a very small space, almost entirely collapsed; the upper lobe could be readily inflated, when it had the cushiony feel of the healthy lung; the lower lobe had a healthy appearance, and could be inflated, except a portion in the posterior aspect; measuring perhaps, an inch in diameter; this portion was partially coated with lymph, and was found to contain two small abscesses, one closed, the other opening externally on the surface of the lung, and internally into the bronchial tube. As the air passed directly through this opening, it was impossible to ascertain whether this part of the lobe could be inflated; the closed abscess contained from one-third to half a dram of disintegrated lung tissue and pus-corpuscles as shown by the microscope; foramen ovale open; weight of liver,  $\frac{3}{4}$  vjss. Stomach and jejunum healthy; the mucous membrane lining the lower part of the ileum and the whole extent of the colon was vascular, and that of the latter considerably thickened, but no ulceration was noticed; mesenteric glands enlarged and of a lighter color than in the healthy state.

**Case 2. M. J.**— was admitted into the hospital, Oct. 7th, 1859, at the age of about four months. At the time of admission she was delicate and suffering from diarrhoea, which was relieved by castor oil mixture. After this she continued to improve until the latter part of October, when her abdomen became distended and tympanitic, and she appeared to suffer much pain. This condition was relieved by aromatic drinks and warm applications, but it continued to return at intervals. Pains were taken to nourish and sustain her, and hopes were entertained of her ultimate recovery.

On the second of November, however, at 10 P. M., she was suddenly seized with violent dyspnoea, which terminated fatally in about a quarter of an hour. Previously to the dyspnoea no cough had been noticed, or other symptom referable to the chest.

**Autopsy—thirty-eight hours after death.**—Body considerably emaciated; slight rigor mortis; on opening the thorax, the left lung was found healthy with the exception of slight hypostatic congestion; the right lung was adherent to the diaphragm, and to a considerable part of the costal pleura by fibrinous exudation; the whole lung appeared somewhat compressed and was non-crepitant; the upper lobe floated in water; the middle and lower sank and could not be inflated or but slightly; this portion of the lung contained a few small abscesses filled with purulent matter, each holding scarcely more than a drop; one or two of these appeared to have opened into the pleural cavity, as the air passed through them in attempting to inflate, but possibly they may have been opened in separating the adhesions; in one of the closed abscesses both pus and exudation corpuscles were found with the microscope; the lung surrounding the abscess contained both kinds of epithelial cells, pus, and exudation corpuscles; two or three ounces of fluid were found in the pleural cavity, consisting mainly of fibrinous flocculi, pavement epithelial cells from the pleura, pus, and exudation corpuscles; the lower portion of this fluid, on standing, contained so much pus as to become gelatinous on the addition of acetic acid; heart normal; liver congested and weighing  $\frac{3}{4}$  ix.; mesenteric glands enlarged; kidneys, stomach and small intestines apparently healthy, but the latter distended with gas; the colon showed considerable vascularity in its descending portion, and near the ileo-cæcal valves, but no ulceration was observed.

### BROOKLYN CITY HOSPITAL.

#### CASES ILLUSTRATING A NEW AND SUCCESSFUL TREATMENT OF VARICOSE VEINS BY THE INJECTION OF PERSULPHATE OF IRON.

[By JAMES M. MINOR, M.D., Attending Surgeon.]

The following cases possess the double interest of novelty and practical utility.

There are none of a similar character on record, except those in which this treatment was adopted subsequently to, and in imitation of, them.

It will be observed that I have introduced a case of *aneurism*, treated with injections of the perchloride of iron, among cases of *varicose veins*, treated with the *persulphate*.

In doing so I have violated the harmony of pathological relation, in order to illustrate the efficiency and innocuousness of the preparations of iron. The first case was in private practice, the others were treated in Hospital.

**CASE 1.—Popliteal Aneurism cured by the Injection of the Perchloride of Iron.**—On the 9th of November, 1857, I was requested by Dr. Jas. Crane to see Mrs. T. I found a small, pulsating, superficial, aneurismal sac, between the right labium and thigh, about the diameter of a Madeira nut, and projecting about half an inch above the surface. From it projected a small nipple-like or rather tubular off-shoot, from which, previous to its ligation by Dr. Crane, arterial blood spouted *per saltum*. Mrs. T.'s account of it was, that about seventeen years previously she had received a severe blow at that point while entering a stage-coach, from the heavy iron hook attached to one end of the "back strap" of the middle seat, causing very severe pain at the time, but of short duration. Is not absolutely sure how long she has felt pulsation, but thinks that about a year since it became very distinct, and assumed the purplish tinge it now has; pulsation was more active at every menstrual period. A careful examination, by alternate pressure upon the femoral, and at a point posterior to the sac, shows a supply trunk, probably from some one of the perforating branches of the profunda femoris in front, and the obturator behind.

Upon consultation between Drs. Crane, Isaacs, and myself, and at Dr. Isaacs' suggestion it was determined to use injections of powerful styptics. This course was adopted in

view of the manifold difficulties in the way of an effort to tie the supply trunks.

There were four several attempts made, at intervals of about a week, with solutions of lactate, muriated tincture, and perchloride of iron, using at the same time Signoroni's tourniquet to control the circulation through the femoral artery, and lessen the tendency to wash away the newly-formed clot. It was impossible to exert much force in controlling the current from the obturator artery, as the finger alone could be used.

The solution of the perchloride alone sufficed, with the aid of the tourniquet, and the recumbent posture, to effectually coagulate the blood and block up the sac. The pain caused by the perchloride was very severe, and continued for more than twelve hours, and was followed by considerable inflammatory action. It was completely successful, and Mrs. T. recovered with entire obliteration of the sac. The tourniquet was kept on for some days, being loosened at intervals, to lessen the intolerable pain caused by the pressure. The filling by granulation of the cavity left where the coagulum came away (which it did by ulceration) occupied some weeks.

The notes of this case having been lost, will account for the omission of some points of interest. They have been drawn out from memory, and by the aid of the patient.

The following cases of varicose veins, treated by the injection of persulphate of iron, occurred in the Brooklyn City Hospital, the notes of which are furnished me by R. P. Moore, M.D., House-Surgeon:

**CASE 2.—Varicose Veins of Leg—Injection of Persulphate of Iron—Cured.**—John Towle, admitted March 1st, 1859 (Dr. Enos on duty), with ulcer from varicose vein on leg, of five years' duration; it has healed repeatedly, but again re-opened. Ordered poultice, and rest in recumbent posture. April 25th.—Ulcers nearly healed. Injected liquor ferri persulphat. gtt. x.\* May 2d.—Veins obliterated at point of injection; neighboring branches still varicose. May 20th.—Ulcers entirely healed, and patient permitted to go out on a pass. Returned drunk, with abrasion of newly cicatrized surface. June 13th.—Discharged cured.

**CASE 3.—Varicose Veins of Scrotum—Injection of Persulphate of Iron—Cured.**—J. T., æt. 22, American, admitted under Dr. Minor Oct. 24th, 1859, with varicose condition of scrotal veins of left side. Has enjoyed very good general health. For six months past has suffered much pain from distended veins of scrotum, extending through spermatic cord to inguinal canal of that side, and also in the testicle; can obtain no relief except in recumbent posture. Ordered cathartic. Suffers with languor and debility from involuntary seminal emissions, after which the pain is much aggravated. Oct. 28th.—Injected four drops of a solution of persulphate of iron (four parts of water to one of persulphate), with Pravaz's syringe, as modified by Tiemann. Patient was made to stand erect, in order to fill the veins, and make them more distinct and prominent—a necessary precaution in such loose tissues as are found in that region. He fainted, but was soon restored by placing him in a recumbent posture. The operation scarcely caused any pain, either at the time or subsequently. A firm coagulum was formed in thirty seconds. Ordered cloths dipped in water to the part, and recumbent posture. Nov. 3d.—The clot formed by persulph. ferri gives indications of coming away by ulceration. Has felt less pain in cord since operation; nor does he feel any pain at the point of puncture. Feb. 6th.—Clot came away last night, leaving a healthy granulating surface. 26th.—Discharged cured.

**CASE 4.—Varicose Veins of Scrotum—Second Injection—Cured.**—James Taylor was admitted a short time after his discharge in November last, with varicose condition of other deep scrotal veins near the cord. The vermiform mass of enlarged veins around the point of former operation are entirely obliterated. Has been variously treated since second admission, but without resort to operative measures.

Feb. 14th.—Veins increasing in size, attended with pain. Injected three drops of a solution of persulphate of iron in the proportion of one part persulphate to two of distilled water, followed by immediate coagulation of blood, as on former occasion, and with as little pain. 15th.—Injection seems to have entirely relieved the pain in the cord, and he expresses himself as feeling better in every particular. 19th.—Continues comfortable. Some pain and heat at point of puncture, where there is an exceedingly hard and prominent tumor. Tumor is close to the cord, and seems in some measure to involve it. Seminal emissions occur at long intervals now. Cold water dressings. 26th.—Clot decreasing in size, but still very hard. No appearance of ulcerating, as on former use of the persulphate. March 1st.—Tumor has steadily decreased in size; but little hardness remains. Veins completely obliterated when injected, as well as all others which were enlarged.

**CASE 5.—Varicose Veins of Leg—Injection of Persulphate of Iron—Cured.**—Carl de Buke, admitted Dec. 22d, 1859, with paronychia of left thumb. Varicose veins in left leg, which he has had for many years. Veins very much distended at one point. Owing to the size of the veins it was thought necessary to insert a larger quantity of the solution than usual. Feb. 11th.—Ten drops of a solution of the strength of one part persulphate to three of water was used. 12th.—A clot has formed, and obstructed the vein; though it does not appear to be so firm as in previous cases. 14th.—Complains of pain at point of puncture, where there is a considerable swelling and redness. Apply cold lotion. 16th.—Inflammation and pain subsiding. Continue lotion. No constitutional disturbance at any time. 22d.—Tumor lessening in size, and redness disappearing. March 10th.—All inflammatory symptoms have subsided, and the vein is obliterated at point of operation.

**CASE 6.—Varicose Veins of Leg—Injection of Persulphate of Iron—Cured.**—James Flemming was admitted December 29th, 1859, with secondary syphilis, and ulcers on right leg; has varicose veins of the same leg, which are increasing in size, and he expresses a wish to be operated on for their relief. Feb. 11th.—Injected as usual, three drops of a solution of the persulphate of iron, one part to four of water. A second puncture was made below the first. 13th.—Coagulum formed, but not so marked as in other cases. No inflammation about punctures. 19th.—Ulcer on leg has improved rapidly since operation. 25th.—Vein obliterated between points of operation. 27th.—Old ulcer cicatrized, and he desires to leave the hospital. —Discharged cured.

It may be desirable to state briefly, the mode of procedure in the injection of varicose veins. A Pravaz's syringe as modified by Mr. Tiemann is the instrument used. This is a very small syringe of vulcanized rubber having a small (almost capillary) canula screwed to its lower end. This canula is cut obliquely at its extremity somewhat after the manner of a pen, ending in a sharp point. The piston rod is graduated to drops, to admit of the use of any quantity however small.

The canula being screwed on, the quantity of the solution desired to be used is drawn in through the canula, which is then plunged into the vein, the patient standing erect. The finger of an assistant is then placed upon the vein, a little above and below the point of puncture, and firm pressure made; the piston is then forced down and the fluid injected. It is important that the pressure on the cardiac side of the puncture, should be sufficient to completely stop the upward current, as otherwise portions of the clot might be carried into the circulation. The pressure need be kept up for a minute or two only.

This completes the operation. The patient is placed in the recumbent posture, and cold water dressings applied, with directions not to rise for some days. The above mode of treatment of varicose veins, would seem to promise a safe, prompt, and painless cure of a most uncomfortable, painful, and sometimes perilous complaint, for which, heretofore, there have been only uncertain and dangerous expedients.

\* Official solution contains 43 per cent. of the solid persulphate.

The persulphate of iron, as far as heretofore used, seems to excite adhesive inflammation alone, thus avoiding that formidable affection pyæmia; and I feel confident in recommending it to the profession, as a safe, simple, and almost certain remedy for varicose veins, and with some qualifications, for *small* aneurisms.

### ST. LUKE'S HOSPITAL.

#### TWO CASES OF MORBUS COXARIUS SUCCESSFULLY TREATED BY AN APPARATUS MAKING EXTENSION AND COUNTER-EXTENSION.

[Reported by EDWARD B. DALTON, M.D., Resident Physician.]

Two boys, one 4, the other 5 years of age, entered the hospital, the one on the 12th of January, and the other on the 2d of February last, both suffering from morbus coxarius.

The symptoms exhibited in these two cases were so nearly identical, and the treatment and progress thus far has been so uniform that they may readily be described together. The only striking difference in the symptoms was, that in the case of the youngest the general health was much more seriously impaired than in the other. In one the right hip, and in the other the left, was the seat of disease. In neither case had there ever been any abscess, or ulcer over the joint. In each there was tenderness, heat, and swelling in that situation, and intense pain was caused by the slightest movement of the limb. Under the direction of Dr. George A. Peters, the attending surgeon, the patients were put upon the use of constitutional tonics, and a few days subsequent to their admission, Dr. Henry G. Davis, of this city, applied his apparatus for the cure of this disease. The treatment by this apparatus consists in first extending the limb for several weeks, more or less, until its length equals that of its fellow, or as nearly so as practicable, and then retaining the limb in position by means of a splint, which, while it keeps up extension, allows the patient to enjoy the advantages of exercise and fresh air. To accomplish the first end, a broad strip of adhesive plaster is applied both to the outer and the inner aspect of the affected limb throughout its entire length, and over these again a third strip is carried spirally round the limb from the hip to the ankle. A bandage is then applied from the toes up, leaving exposed and free the lower extremities of the side straps, to which are attached bands of webbing made to buckle in a loop beneath the foot. To this loop is attached a cord traversing a pulley at the foot of the bed, and sustaining a weight. In each of these cases a weight of three pounds was first used, increased after a week to four pounds. A few days after the application of this apparatus, the relief experienced by the patients was very apparent. The pain in the joint, as well as that produced by motion, began at once to diminish. This was strikingly evident from the fact that the patients' sleep, which had before been incessantly broken by their own involuntary movements, became much more quiet. Their general health, too, rapidly improved. This amendment became daily more marked, until after some four or five weeks all suffering had ceased. The general health of both patients was excellent, and a very considerable motion of the affected joints caused no complaint. Within a few weeks subsequent to the commencement of this treatment, the splint was frequently substituted temporarily for the cord and weight. This splint consists of a narrow bar or band of steel, adapted to the form of the outside of the thigh and leg, and having a hinge-joint near its middle, capable of being made immovable. The counter-extension is accomplished by means of a perineal band of India-rubber, fastened at either end to a cord of cat-gut which traverses a small ring at the upper extremity of the splint. The splint itself terminates just above the external malleolus, where it is kept in place by the band of webbing attached to the outer adhesive strap, which is carried up over the end of

the splint and fastened by a buckle attached to the shaft of the latter some four inches above.

The splint is applied with its upper and lower portions forming an angle at the hinge, and extension is produced by obliterating this angle, and thus bringing the splint throughout its entire length into contact with the bandaged limb. The movements of the hip-joint are not interfered with. The application of the splint is the work of only a few moments, and gives rise to no pain or inconvenience. In these two cases it has now been worn daily for several weeks, and only removed at bed-time, to be immediately replaced by the weight. In both instances the limbs are kept constantly at their natural length, and can be moved with great freedom without causing any pain. The tenderness, heat, and swelling over the joints have long since subsided, and the patients are both in the enjoyment of fine health. The light and compact character of the splint enables them to be dressed, and to have their regular exercise, and to be out-of-doors whenever advisable.

### LONG ISLAND COLLEGE HOSPITAL.

#### CASES OF PARALYSIS CONNECTED WITH DENTITION; WITH REMARKS BY PROF. F. H. HAMILTON.

[Reported by JOHN G. JOHNSON, M.D.]

There have been recently presented to the class six cases of paralysis connected with dentition.

*Case 1.*—A little girl nineteen months of age, in whose case the left arm is paralysed. There is wasting of the deltoid and of the muscles of the arm and forearm—with complete loss of power. The paralysis is of three months standing.

*Case 2.*—A girl of three years of age—paralysis of the left leg. The heel is raised considerably from the ground. The muscles of the leg are more wasted than those of the thigh. In attempting to walk, she drags the foot sideways.

*Case 3.*—Mary Gorham, two years and one month old. Eight months ago she had a fever, after this the mother noticed that the child could not use the left leg. There is a tendency of the foot to rotate outward, she drags the toe. Paralysis is mostly from the knee downwards. There is wasting of the limb. In this case it is to be attributed to the fever. Prof. Hamilton has never seen a case in which infantile paralysis could be attributed to the abuse or use of calomel.

*Case 4.*—Boy three years and a half old, in all respects healthy, except loss of power of left leg. No traceable cause, unless diarrhoea attending teething. The limb is wasted and heel is elevated, there is dragging of the toe—sensation in the limb is perfect.

*Cases 5 and 6.*—Were both boys, and the paralysis confined to the right leg—presenting the same symptoms of wasting of the limb, loss of power, elevated heel, &c.; no assignable cause for the paralysis.

*Remarks.*—Infantile paralysis occurs generally at some time during the period of first teething, and seems to have a more or less direct connection with this process. There are several periods in life, in which the system or portions of the system undergo remarkable changes, and great nervous derangements are apt to ensue. The period of the first dentition, is one of these, and among the consequences of the nervous disturbances occasioned by the development of the teeth are convulsions, hydrocephalus, diarrhoea, and *paralysis*. The other periods to which I allude, are puberty in both male and female, and "the change of life," or the period of cessation of the menses in the female. I think that I have observed, also, that at the period of "change of life" in the male, paralysis and cerebral apoplexy are exceedingly liable to occur.

Infantile paralysis is more common in the legs than in the arms; yet we see it occasionally in the arms. It generally



exists but in one leg, occurring in most cases suddenly, and not unfrequently after a diarrhoea or fever of some form, or after exposure to the cold. Its frequent sequence to some temporary illness has often led parents to suppose that it was due to the medicine which had been given, especially to mercury; but I have never been able to trace it to the use of mercury, in any form. I have never seen the paralysis complete; it being, in the case of the lower extremities, confined mostly to that portion of the limb which is below the knee, and existing much more in the nerves of motion than in those of sensation.

The child can generally stand upon, and even walk with the limb tolerably well; but the foot turns out whenever the weight of the body rests upon it, and the gait is unsteady and insecure. He is especially unable, when sitting, to raise and extend the leg upon the thigh, but he can generally flex the thigh upon the body without difficulty. After a time the muscles become sensibly diminished in size, especially the muscles of the leg; and if the paralysis continues, the leg does not increase in length quite as rapidly as the other, and the foot becomes more and more turned out at the ankle.

*Treatment.*—First of all, if the case is seen soon after the occurrence, the bowels should be well evacuated, and the condition of the gums should be looked to. The child should then be turned out of doors, and be permitted to gather health and strength by exercise in the open air. By use, mainly, are these muscles to be again restored to action. The little patient should therefore be encouraged to walk, and if old enough he must be directed to sit occasionally upon a chair and swing his leg back and forward in flexion and extension. No apparatus ought to be employed to support the ankle or the knee, unless these joints are becoming greatly deflected, or the limb is totally unable to support its weight. When apparatus is substituted for the muscles, the muscles being thrown into disuse, are not in a condition to gain strength. Upon this point there is a popular error which needs to be corrected. When a young man begins to stoop, or his spine begins to fall to one side or the other, his friends tell him he must get a shoulder-brace or a spine-supporter—and there are always plenty of them hanging in the windows of drug-shops, patented and recommended for this very purpose. Now the probability is, that this fall of the shoulders or curvature of the spine, is entirely due to muscular weakness. The great trapezoid does not pull the scapula well back, and if we pull them back with a shoulder-brace, leaving the muscles nothing to do, they will rapidly become atrophied, and when the brace is taken off the shoulders, will fall forward more than ever. It would be much better to put the brace in front, and tie the shoulders forward, and then by the constant antagonism the trapezoid would be strengthened. Those persons who carry weights upon their heads, grow straight; the spine being made to erect itself by the action of the muscles, whose power is thus developed and perfected. It is this use of the muscles in carrying the gun, which makes the soldier and the hunter so erect. The same principle applies to these cases of infantile paralysis. The limb should be kept in constant use, and no apparatus should be employed to support the limb, except in the few extreme cases mentioned. It is well, also, to bathe the limbs in cold water once a day, and to rub them freely afterwards. Galvanism and electricity also deserve a trial.

Usually the recovery is very slow, extending through a period of several years; but I have been enabled to follow the history of enough of these cases to warrant me in assuring the parents that they will almost certainly improve, and that there is a reasonable probability of a final and complete recovery.

**CHANGE OF STATION.**—Assistant Surgeon, John F. Hammond has been ordered to relieve Assistant Surgeon John Campbell at West Point.

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## American Medical Times.

SATURDAY, JUNE 2, 1860.

THE AMERICAN MEDICAL TIMES, the first number of which we now present to the profession, will give to most of our readers the first intimation which they have received, that important changes have taken place in the *NEW YORK JOURNAL OF MEDICINE*. As no preliminary announcement has been made, some may be led to believe that these improvements have not been long contemplated, and have therefore been completed without due reflection and preparation. We deem it but an act of justice to them, and equally so to ourselves, to state briefly the reasons which have led to these changes.

With the issue of the last number, THE NEW YORK JOURNAL OF MEDICINE completed the seventeenth year of its publication, having been established in July, 1843. It was originally projected by SAMUEL FORRY, M.D., who during his brief career in this city won, by his profoundly scientific essays, an enviable fame, and by his gentleness and urbanity, an abiding place in the hearts of his professional brethren. In his prospectus Dr. FORRY says:—"The leading objects sought in the establishment of this Journal are, to elevate the character and dignity of the American Medical Profession generally, and especially to afford a medium, free from all individual interests and party, through which the rich results of the experience of the profession in this city, much of which is now lost, may be communicated." That these praiseworthy objects have been wholly realized, the history of that periodical fully attests. Under the judicious editorial management of PROF. CHARLES A. LEE, and S. S. PURPLE, M.D., it acquired during the first ten years of its publication, the entire confidence of the profession, and a circulation second to no other similar periodical in this country. Since that period it has pursued the even tenor of its way, maintaining its position as a high-toned scientific journal, and never deviating from the strictest rules of professional decorum and courtesy. In no instance have its pages been sullied with the personal reflections or improper insinuations and allusions which are liable to enter the discussions of authors who are advocating favorite theories. As a medium for the communication of scientific intelligence, it has always been a free, independent journal, subject to no individual or party interests of any kind whatever. And that it has proved an acceptable organ of the profes-

sion, the thirty-four volumes now completed, filled with elaborately written monographs and papers abundantly prove.

But well as that periodical has served its day and generation, and eminently as it has realized the great idea of its founder, the important question has recently occurred to the minds of many of its friends; is it to-day subserving in the highest degree the best interests of the profession? During the period of its existence, what marvellous changes have taken place in the social condition of our people! How rapid has been their advancement in population, in the aggrandizement of wealth and power, and in all the arts of a higher civilization! Within the last seventeen years, a complete revolution has occurred in nearly every department of industry. Science has demonstrated and art developed in multifarious methods, the truest aids to human progress. Every department of industrial enterprise has been metamorphosed by the applied sciences. The means and methods, the instruments and appliances of that period, are now discarded or treated with ridicule and contempt. But it is not to any occult causes, that we are to attribute this remarkable stimulus of the human intellect, which has so marvellously revolutionized society; the application of steam to travel, and electricity to the communication of intelligence, have been the most efficient agencies in effecting this result. They have so compacted society however widely scattered, and centralized commerce, science, and letters, that the people of every part of our widely extended republic, with all their diversity of interests, are brought in their thoughts and sympathies within the circle of a single community. With these improvements in man's social condition, commerce and every branch of industry keep pace and shrewdly seize the golden opportunities as they occur, to enlarge the domain of their operations. With these increased facilities for inter-communication comes a demand upon the press for the more frequent and rapid diffusion of intelligence; monthlies have changed to weeklies, weeklies to dailies, and dailies must have almost hourly editions.

Scientific medicine now partakes largely of that spirit of inquiry and restless activity which characterizes the age. In every department ardent and impulsive adventurers, with all the aids of modern invention, are enlarging the bounds of knowledge, and daily unfolding truths and principles of the greatest practical utility. These developments in the medical sciences are not now made at long intervals, but they are daily and almost hourly occurrences. He who maintains a familiar acquaintance with latest improvements, even in the single department of medicine, must in our times be a student of unremitting application. And not only is there an active spirit of inquiry and research in enlarging and more thoroughly exploring the domain of medical science; but our hospitals, the great repositories of accurate observation, and our schools, where these facts are reduced to systems and made available, are heartily co-operating in the great work of medical education, and the diffusion of practical knowledge. This rapid development of every branch of medicine, and the increasing desire on the part of the profession at large, for the earlier and more frequent dissemination of scientific intelligence, imperatively demands the co-operation of the metropolitan medical press.

These are some of the considerations which have led to the conclusion that this journal, by a change of form and more frequent issue, might be made far more conducive

to the interests of the profession, both of the city and country, than it is at present. However well it may have been adapted to the period of its first publication, it cannot to-day in its present form faithfully represent New York, with her population increased three-fold, her numerous and well appointed hospitals, her flourishing schools of medicine, and her gradual centralization of medical interests. With a full knowledge of our increased responsibilities and labors, we have, with the sole object of rendering this Journal in the highest degree useful to the profession, determined to exchange bi-monthly for weekly medical journalism. We are aware that other laborers have preceded us in this field, fruitful at least in harassing cares and constant toil, and we desire to be co-workers with them in the development of its resources.

In entering upon the duties of weekly medical journalism a word of explanation in regard to its spirit and mission, and the special duties and obligations which we feel are imposed upon us, is due to the professional public.

The very liberal arrangements which have been made by the publishers, for securing full reports from all the hospitals, and the various medical institutions and associations in the cities of New York and Brooklyn, cannot fail to give the highest practical value to the journal, and will tend strongly to promote the interests and multiply the good works of those several sources of medical intelligence, for

"A chiel's amang them takin' notes,  
An faith he'll print them."

In every department of medical science and literature, in surgery, hygiene, medical polity, special pathology, and practice, distinguished contributors have already been secured, and we cordially invite the coöperation of others in all sections of our country. Original observations and researches, scientific and practical reports, condensed *résumés*, properly reported cases, and individual facts, will be gratefully received, and properly acknowledged. It is desired that these pages shall furnish an acceptable and popular medium for the individual and united utterances of medical men on all subjects connected with the progress and interests of medical science, the most advanced views in sound medical philosophy, and the defence or the criticism of both the old and the new, as well as the proper discussion of questions relating to the common interests, obligations, and wants of our sacred profession.

In connection with the department of Hygiene and State Medicine, it is designed to keep up an Epidemiological Record, that shall embrace a reliable history of epidemic and endemic maladies throughout our country and the world. In order to accomplish this important purpose, we cordially invite the attention and correspondence of all competent observers of epidemic or of epizootic diseases.

While this Journal designs to present to the profession an accurate, full, and impartial record of medical progress and practice, as set forth in the foregoing remarks, it proposes also to undertake another and more difficult work. It is the determination of its projectors, and the wish of its publishers, that its editorial columns should faithfully and fearlessly express the highest sentiments, the noblest aspirations, the common desires, the just criticisms, and the friendly warnings of all those who by precept and example strive to honor and fulfil the sacred vocation of the physician.

Truthfully to mirror forth, and, at proper times, to lead the sentiments and the progressive activities of the medical profession—from week to week vigilantly striving to daguerreotype the features and interpret the real significance of passing events—yet,

\* \* \* "naught extenuate,  
And naught set down in malice,"

will be the constant and conscientious endeavor of this Journal. By every suitable means shall its pages encourage and promote the intimate and fraternal association and communion of medical men, ever striving to elevate the standard and ennoble the quality of medical education and professional ethics. To this end we desire that its columns should faithfully and acceptably utter for the whole profession the noblest sentiments and the most advanced opinions of those who best have loved and honored its high vocation.

The sacred unity, the high obligations, and the mutual interests and common rights of medical men will be recognized and encouraged on every page and in every paragraph, and under no circumstances will partizan and polemical discord be permitted to supplant the harmonies of professional charity and good-will. Fearlessly it will defend and promulgate the claims, the dignity, and the legitimate undertakings of the medical profession; and not less boldly will it endeavor to expose and root out those pestilent evils that disturb the peace, and threaten the security and usefulness of professional associations and medical institutions, and which seriously depress the popular status and degrade the character of the profession at large.

In fulfilment of its mission as the faithful defender of the sacred trusts and the fraternal interests of medical life, this Journal will endeavor, by precept and example, to inculcate a conscientious regard for all the ethical proprieties and relative duties of the profession; and, in view of the obligations of humanity, and the sanctions of divine law, we shall, by every consideration and event, strive to illustrate and increase the professional and the popular estimate of that boon—*human life*—which in hospitals, asylums, almshouses, or penitentiaries, as well as in the homes of the people, is still the most sacred and precious of gifts divine.

In this spirit, and regarding physicians as the appointed ministers and conservators of life and the public health, no efforts will be spared, on our part, to keep posted in all that relates to the management and experience of the public institutions in our midst. Especially will Hygiene and every question relating to human health or public salubrity receive our most vigilant and faithful attention; while the enormities of empiricism, and every form of charlatanry, whether within or without the pale of the profession, will invite continual exposure and unsparing criticism.

With earnest endeavor and coöperation to secure for the profession a clear and universal recognition of its true status and mission, and believing that in our national Republic the medical profession is called upon to erect its own standards, and define its own rights, and the laws which shall govern its members, we shall steadily labor to advance the great primary objects of the AMERICAN MEDICAL ASSOCIATION, as the grand Congress of letters, polity, and ethical law, for the Republic of American Medicine; and with equal earnestness shall we endeavor to inculcate the reciprocal obligations and claims of the profession.

## Reviews.

REPORT OF PROF. VALENTINE MOTT'S SURGICAL CLINQUES IN THE UNIVERSITY OF NEW YORK; Session 1859-60. By SAMUEL W. FRANCIS, member of Dr. Mott's Surgical Staff. New York: S. S. & W. Wood. 1860. 12mo.

DR. MOTT, if not the originator of clinical surgery in this country, has at least imparted to it a character and an importance in the curriculum of medical studies, which, until his day, did not attach to it. In the early part of the present century the surgical clinics of which this city could boast were exceedingly few, and the student who sought to verify the text of his authorities upon the morbid living body had to pick up his information by desultory grains wherever he could obtain it. But Dr. Mott at once gave to that science an upward impulse, and furnished a new field of investigation to beginners. Illuminating this department by the bold exploits of a genius which is equal to any requirement however hazardous, and to any undertaking however delicate or complex, he has given to American surgery a position and a weight in the eyes of other nations, which, but for him, it would not yet have obtained. Like Ambroise Paré he appeared to have thoroughly analyzed the facts in every department of his great specialty, and is therefore able to enunciate opinions at once exhaustive and irrefragable. The clinics of such a man must possess, consequently, a magistral character, and he whose privilege it may be to listen to those wise sayings uttered almost in the language of intuition, may well congratulate himself upon his good fortune.

To preserve the memory of some of the aphorisms of his great master, a young medical practitioner of this city, Dr. Samuel W. Francis, has, with an earnest and truly laudable ambition, compiled them in the form of a living book whose title forms the prefix to this article. We say *living* book, and we say it advisedly, because the opinions of such a mind as Dr. Mott's can never die, and he whose name is in any way associated with them, must in some degree share their immortality. Dr. Francis's work belongs to a rare but most useful class of medical publications, viz. general clinical records. It is true, that we have special records on various departments of medicine, but, outside of magazine contributions from hospitals, the *general clinical* record of none of our surgeons or physicians has ever before been compiled by itself. It is nineteen years since ANDRAL published his celebrated *Clinique Medicale, ou Choix d'Observations*, a work which passed through four editions, and in 1855 Roux gave to the world his *Quarante Années de Pratique Chirurgicale*, another magnificent contribution to the department of clinical surgery. Both of these works have acquired a very deserved celebrity in Europe, an exponent in fact of the necessities which they answered abroad, and which necessities, existing in like manner among ourselves, Dr. Francis has sought to meet in a most effectual manner.

It was certainly a task of great difficulty as well as delicacy for a young man to report the *dicta* of his surgical master, from the dry, brief, and sententious utterances alone tolerated at a clinique. Were they stereotyped in the precise language uttered, a form at once conversational and disconnected, we should not read them with as much pleasure as we do now. "Report me and my cause aright," is



the prayer of a dramatic worthy, deserving at all times to be repeated, for, truly, a poor report is worse than none, since it tells a falsehood throughout. All these things young Dr. Francis has most constantly kept before his mind's eye in the little volume before us. Well and carefully has he pondered the worth and the weight of words, and having done so, he proceeds with an inherited elegance of expression to recite all the circumstances necessary to a clinical history of each case. Clear and concise in description, thoroughly exhaustive of the precise idea of Dr. Mott, in the language which he employs to convey it to us, he glides on *densis et brevis et semper instans sibi*, through the recital of nearly an hundred cases, never once sacrificing the spirit of his master's opinions to the temptations of a turgid diction. A passage selected at random, and which our eye has just rested upon, will impart a better idea of the nervous, epigrammatic style of the author, than any description we can indite. He is speaking of gun-shot wounds, and thus describes their character in a few terse sentences.

"The pain is of the peculiar character which belongs especially to gun-shot wounds. This kind of solution of continuities embraces all the features of every species of wound to be met with in surgery. The great danger to be apprehended in all cases of a similar nature, is, that the sudden shock produced upon the nervous system, like railroad fractures, or accidental scaldings, reduces the patient at once by instant prostration; or the reaction may terminate in dangerous inflammation, which too often ends the life of the sufferer by the sloughing and gradual mortification of the surrounding parts." p. 72.

We cannot dismiss this little book, which in its typography and mechanical execution, and the engraved portrait of Dr. Mott accompanying it, is most truly one of the memorabilia of surgery apparelled in Elzevir style, and a volume which both old and young practitioners will do well to place by the side of Chelius and Skey, without alluding to a feature in its physiognomy, which, although entirely unprofessional in aspect, may yet serve to "point a moral" in this generation of dry-as-dust hearts. It is the simple, earnest, affectionate dedication of this, the first-fruits of the author's literary and professional labors, to his brother, Dr. Valentine Mott Francis. Whatever other merits the author may evince, not the least is, a truly large and grateful heart, solicitous lest any who has cheered its hours of trial and assisted at its dear-bought triumphs, should not share in fullest measure the well-earned prize. Such lessons between brother and brother exalt humanity, and teach us that it is as noble in man to bear witness to, as it is to perform "the thousand nameless, unremembered acts of kindness and of love."

**CLINICAL LECTURES ON THE DISEASES OF WOMEN AND CHILDREN.** By GUNNING S. BEDFORD, A.M., M.D., Professor of Obstetrics, the Diseases of Women and Children, and Clinical Midwifery, in the University of New York. Sixth edition, carefully revised and enlarged. New York: Samuel S. & William Wood. 1860. pp. 653.

This is the sixth edition of a work now so generally and favorably known in this country and Europe as to require from us no other notice than the issue of a new and improved edition.

We are glad to learn that the author is preparing a work on the Principles and Practice of Midwifery; which we doubt not will meet with an equally favorable reception from the profession.

## Reports of Societies.

### NEW YORK ACADEMY OF MEDICINE.

STATED MEETING, MAY 2d, 1860.

JOHN WATSON, M.D., President, in the Chair.

#### DISCUSSION ON CROUP.

DR. WATSON referred to the following case of croup that occurred in his practice during the past two weeks, for the sake of asking a question that originated in his own mind during the progress of the disease.

He said that after the last meeting of the Academy, he found a message requesting his attendance on a case of croup. He found it to be a very severe one, and resorted to the usual emetic and depressing treatment without any benefit. The disease continued with unabated severity for several days, during which time he was uncertain whether his little patient was going to live or die.

When it had apparently passed into the stage where cyanosis was beginning to show itself, as a last resort, 3 or 4 grains of turpeth mineral was given, which was followed in two or three minutes after with vomiting. The mineral operated occasionally, at longer or shorter intervals, during two or three hours afterwards, at the end of which time bile made its appearance in the materials vomited as well as in the stools. This state of things was attended with relief to the difficulty in respiration, and was the first step towards recovery.

In answer to a question put to him by the mother Dr. Watson stated that he had never seen a case in which a child died of a second attack of croup, and consequently gave a good prognosis. He asked the members their experience upon the subject.

The experiences of Drs. Buck, J. M. Smith, Blakeman, Wooster, Sterling, Anderson, Hubbard, Bolton, Woodhull, Pond, and Finnell substantiated the views of the President.

Dr. J. P. GARRISH stated that he had met with at least four or five cases of a second attack of croup proving fatal.

Dr. WATSON.—What was the character of the primary attack?

Dr. GARRISH.—It was a genuine inflammatory croup. In one instance a false membrane was thrown up, and in three months after the second attack proved fatal.

Dr. WATSON.—Were any of the second attacks associated with scarlet fever?

Dr. GARRISH.—None.

Dr. GARDNER did not recollect any fatal case from a second attack in his own practice, but referred to one that had occurred to Dr. Clark, of Newark. The patient died at the age of about twelve years, of diphtheria, after having suffered from at least twenty attacks of the severest forms of croup. In not a few of these attacks false membrane was discharged from the air passages.

Dr. PEASLEE referred to a case of membranous croup that was under his care, in which membrane was expelled and the child recovered. He was told that the patient was seized with a second attack of croup and died. He, however, on questioning the mother, had some doubt regarding the existence of the second attack of the same disease. He also recollected another instance of a child which died under his care, and which was said to have had the disease once before.

He was inclined to the belief that a severe attack of croup was a sufficient guarantee against a fatal attack of the same disease. Still he did not see the reason why there should be an immunity from simple tracheitis or bronchitis and the child die from one of these.

Dr. FOSTER recollected a case of croup that he attended some two years ago; membrane was discharged and

the child recovered. About six months afterwards, he was called in consultation to see the child die of a second attack.

Dr. VAN PELT had seen a case die which was said to have had croup once before.

Dr. BATCHELDER thought he knew of one or two cases that had proved fatal after a second attack, but he was unable to fix his mind upon them with any degree of distinctness.

Dr. WATSON stated that in the case related by him the child had a strong deep voice, showing that the opening in the larynx was large. He asked in that connection whether any of the members had noticed such a state of things to exist in any of their cases that terminated favorably.

None of the members however, seemingly, had their attention drawn to the fact.

On motion of Dr. Woodhull the whole subject was laid on the table for discussion at a future meeting of the body.

The Academy then adjourned.

#### STATED MEETING, MAY 16TH, 1860.

JOHN WATSON, M.D., President, in the Chair.

The subject of discussion on croup was continued from the last meeting.

Dr. GARRISH, in reference to the treatment of the disease, stated that he had derived a great deal of benefit from the inhalation of the fumes of cinnabar.

Dr. GRISCOM stated that he had never seen a second attack of croup in the same child. He did not think that the treatment employed by Dr. Garrish was of any more use than so much heated air or vapor to the part, and was disposed to this belief because, in the first place he could not see how any absorption of the fumes could take place through inflamed parts, and more especially if covered by membrane. In the second place he had seen very decidedly good results from the inhalation of the vapor of warm water, and in several instances the good effect was permanent. He did not think it possible that the cinnabar used in that way would produce any of the specific effects of mercury.

Dr. GARRISH replied that he had in all the cases referred to first resorted to the vapor of marsh mallow tea. He believed that the cinnabar produced a specific effect when thus administered in the same way as in syphilitic affections of the throat.

Dr. RAPHAEL could not recall any case of secondary attacks where the first was of a severe nature. There was one point in reference to the character of the disease, upon which he wished to hear the opinion of the Academy. He had read in some French journal (which one he was unable to remember), an account by a physician, who stated that he had never seen a fatal case of croup in a child who had enlarged tonsils, and for that reason discouraged the removal of the tonsils in children. Dr. R. could not remember any such in his own practice.

Dr. JACOB did not remember to have diagnosed two cases of croup in the same individual.

Dr. VOSS had never seen a second attack in the same individual. He stated that in one of the French journals there was a report of six cases where tracheotomy was performed a second time, and four out of this number recovered. He himself had performed the operation twice on the same child with a good result.

Dr. WATSON asked if it was clear in these cases that the second attacks were not due to obstructions which were the results of the previous operation.

Dr. VOSS replied that the shortest interval between the attacks was six months, while in some others it was a year or more.

The PRESIDENT summed up the discussion by saying that

the experience of the Academy went to show that secondary attacks of croup of a fatal character were very rare.

#### SUDDEN DEATH DURING LABOR.

Dr. A. K. GARDNER next proceeded to read the details of two cases of women in labor, one of whom was suddenly seized with coma, difficult respiration with bloody expectoration, and died fifteen minutes after she was attacked; the other had very much the same symptoms of trouble in the lungs, but without coma. Both cases were largely bled, and the second recovered. In the first case he thought that there was pulmonary apoplexy, and that the brain was affected secondarily. [The paper went on to give the pathology of pulmonary apoplexy of the lungs, quoting various authors in regard to the proper definition of the term.]

Dr. JOS. M. SMITH asked if the condition of the heart in either case was carefully examined.

Dr. GARDNER remarked that in the first case he had not seen the patient before, and consequently had made no such examination.

Dr. WATSON asked on what symptoms Dr. G. founded the diagnosis of pulmonary apoplexy in the first case?

Dr. GARDNER stated that the diagnosis was made nearly ten years after the patient died, and then it was only by comparing it with the second case, which had taken place only a few months ago, that he was able to satisfy himself of its character.

Dr. THOMAS thought that the subject of pulmonary apoplexy was properly estimated in works upon obstetrics. The occurrence of hemoptysis, one of the symptoms of the accident, certainly was frequently alluded to. Congestion of the lungs, which would bring about such a condition of things, was as likely to occur during labor, as from any other muscular exertion. It struck him, however, that in neither of the two cases narrated, was a proper diagnosis made.

The symptoms of pulmonary apoplexy, as he recollected them, were, in the first place, hurried respiration; in the second place, hemoptysis; and that, unless the hemorrhage into the parenchyma of the organ was very great, death took place very slowly. During all this time the intellect is perfectly clear. In Dr. G.'s first case death took place in the course of fifteen minutes, the patient being profoundly comatose. He thought that such symptoms belonged to cerebral apoplexy.

In this connection he referred to a case in point, which occurred to him in Bellevue Hospital:—A German woman, a short time previous to admission, had fallen down suddenly, and had become speechless. When Dr. T. saw her, her hands and feet were quite cold; notwithstanding she was constantly about the ward. She would go where water was, but would not drink. The thought occurred to him that she might be hungry or thirsty, and putting such a question to her, he was answered by a nod. But it was found that she was unable to swallow. The House-physician then introduced into her stomach, by means of the stomach pump, milk and beef-tea. This mode of treatment was carried out for fifteen days, in the meantime her voice slowly returned. The symptoms were such as to lead to the suspicion that there had been an effusion of blood at the base of the brain, at the roots of the nerves which govern speech and deglutition.

The Saturday night previous to the Monday she was to be discharged, she was observed by the nurse to snore unusually loud, and all attempts to wake her were found to be useless, and she died not long after.

On making the post-mortem examination nothing was found to exist to account for the symptoms, except a clot at the base of the brain.

He thought that Dr. G.'s case had nothing to stand upon in the way of a diagnosis, more particularly as no post mortem examination was made.

"With regard to the second case," said he, "it is known

that the condition of uræmic poison produces cedema of the lung, and that it is one of the results of uræmia which most commonly produces death. I have certainly seen a case terminate fatally in such a way, in which the post-mortem examination was made by a number of gentlemen, who looked into the case very carefully, and concluded the issue due to such an accident. In that case, for some time previous to death, there was abundant and frothy expectoration, which became more or less tinged with blood. I would ask why the diagnosis of cedema of the lungs would not better cover the symptoms in that case of Dr. Gardner's, rather than those of apoplexy, which is known to be very rare?"

Dr. GARDNER remarked, that in regard to his first case, Dr. Thomas had left out entirely any explanation of the bloody sputa—a state of things which, as far as he knew to the contrary, was never met with in cases of cerebral apoplexy. We find that cases of convulsions dependent upon apoplexy, at the time of labor, are not at all uncommon; and he presumed that there are very few persons who have not seen the symptoms of apoplexy occurring at that time. In the first case he thought that the effusion into the brain was simultaneous with that of the lung.

In regard to the subject of apoplexy of the lung being recognised in the works on obstetrics, we find mention made of hemoptysis which is treated of as occurring in the course of labor from a cold, from diseases of the throat, from the rupture of a blood-vessel, particularly those laboring under phthisis, but where such a sudden engorgement of the lung exists, as in the cases narrated, he did not think Dr. Howard could point out anything that even alludes to it. He had seen cases with symptoms that are somewhat similar, and where pneumonia existed at the time of labor.

In conclusion, Dr. G. stated that in his cases the respiration was very much hurried.

Dr. FINNELL stated that out of a very large number of post-mortem examinations which were made by him, he had met with but three cases of true pulmonary apoplexy. He applied the term pulmonary apoplexy to those cases where there was a sudden laceration of the lung tissue (which had been previously sound), and the effusion of a greater or less amount of blood, leaving out of consideration altogether those cases of hemoptysis occurring with the tuberculous disease or in consequence of passive congestion of the organ as in cardiac disease. In the three cases alluded to, there was a free discharge of blood before death; and in all, death took place gradually in the course of from five to eight hours. One occurred in a woman four months pregnant.

Dr. Jos. M. SMITH wished to make a few remarks, that would apply to the pathological anatomy of pulmonary apoplexy, without any reference to its connexion with obstetric cases. In regard to the term pulmonary apoplexy, he believed it was first used by Dr. Rush, who, however, did not give it a precise definition. If he remembered correctly, cases of that sort were described by Laennec under the head of hemoptysis proving fatal, without a sufficient explanation in relation to the amount of blood that had been expectorated. At the post-mortem examination of such cases, he (Laennec) found that there was laceration of the parenchyma of the organ, with effusion of blood into the intervesicular substance, and also in the air cells themselves, and that the clot was as circumscribed and distinct as that found in cerebral apoplexy.

In conclusion, he asked if it was not possible that a skillful auscultator could detect the existence of such a condition, before death?

Dr. GARDNER, in relation to the rapidity of death in his first case, thought the fact could be accounted for by the occurrence of such an accident during the great muscular exertion attendant upon labor pains.

Dr. JACOB agreed with Dr. Thomas in supposing that the second case was one of pulmonary cedema. In his opinion the word apoplexy meant nothing else but the effusion of blood through the ruptured vessels into the substance of an organ. In answer to a question from Dr. Gardner, he stat-

ed that cedema was a consequence of congestion, and was not to be looked upon as the same disease.

Dr. HUBBARD agreed with Dr. Thomas, in supposing the second case to be one of cedema.

Dr. GRISCOM regarded the first case as one of ordinary cerebral apoplexy—from the suddenness of the attack, and the entire loss of consciousness—and he looked upon the lung difficulty merely as secondary.

Dr. THOMAS stated that he had only seen one case of pulmonary apoplexy. It occurred in a powerful Irishman, who was suddenly seized with difficulty of breathing and hemoptysis caused by an attempt to lift a large boulder from its bed in the earth. The diagnosis was verified by a post-mortem examination.

Dr. FINNELL, in this connection, stated that in his cases free hemorrhage was the first symptom, there being no frothy fluid expectorated in either case.

## Medical News.

### ARMY MEDICAL INTELLIGENCE.

DEATH OF SURGEON WHEATON.—Surgeon Walter V. Wheaton, the senior surgeon of the U. S. Army, died recently in Philadelphia, æt. 73. Dr. W. was born in New York, but as a citizen of Rhode Island, was appointed a Hospital Surgeon on the 28th of March, 1813. He served in this capacity until the close of the war with Great Britain, and at the reduction of the army in 1816, was retained in service—with the rank of Post-surgeon, and in the same year was appointed surgeon to the 2nd Regiment of Infantry. In 1821 he was transferred from the regimental service to the staff corps, where he remained in active service until within a short time of his death.

SURGEON SATTERLEE.—We are happy to state that Surgeon Richard S. Satterlee is recovering from his late severe accident, and will probably ere many days be again able to attend to the active duties of his office as Medical Purveyor of the United States Army. The duties of the army purveyor stationed in New York are onerous and of great responsibility. All the regular supplies of medicine for over a hundred medical hospitals are purchased by him, and distributed to the different posts throughout our immense area. Instruments are selected, books purchased, and an infinity of incidental duties attended to, making the office by no means a *sinecure*.

### MEDICAL DIARY OF THE WEEK.

Monday, June 4.	{ CITY HOSPITAL, Surgery, Dr. Watson, half-past 1 P.M. BELLEVUE, Obstetrics, Dr. Taylor, half-past 1 P.M. EYE INFIRMARY, Diseases of Eye, 12 M.
Tuesday, June 5.	{ BELLEVUE, Medicine, Dr. Thomas, half-past 1 P.M. CITY HOSPITAL, Surgery, Dr. Markoe, half-past 1 P.M. EYE INFIRMARY, Diseases of Ear, 12 M. OPHTHALMIC HOSPITAL, Drs. Stephenson & Garrish, 1 P.M.
Wednesday, June 6.	{ ACADEMY OF MEDICINE, half-past 7 P.M. EYE INFIRMARY, Operations, 12 M. CITY HOSPITAL, Medicine, Dr. J. M. Smith, half-past 1 P.M. BELLEVUE, Surgery, Dr. Sayre, half-past 1 P.M.
Thursday, June 7.	{ SANITARY ASSOCIATION, No. 19 Cooper Institute, 8 P.M. OPHTHALMIC HOSPITAL, Drs. Stephenson & Garrish, 1 P.M. CITY HOSPITAL, Surgery, Dr. Watson, half-past 1 P.M. BELLEVUE, Medicine, Dr. Loomis, half-past 1 P.M.
Friday, June 8.	{ CITY HOSPITAL, Surgery Dr. Markoe, half-past 1 P.M. EYE INFIRMARY, Diseases of Eye, 12 M.
Saturday, June 9.	{ BELLEVUE, Surgery, Dr. Church, half-past 1 P.M. OPHTHALMIC HOSPITAL, Drs. Stephenson & Garrish, 1 P.M. CITY HOSPITAL, Medicine, Dr. J. M. Smith, half-past 1 P.M. EYE INFIRMARY, Diseases of Ear, 12 M.

### OPERATIONS (THIS DAY), SATURDAY, JUNE 2.

BELLEVUE HOSPITAL, by Dr. Parker:—Amputation at shoulder-joint, for enormous morbid growth of the arm; excision of knee-joint.



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## Bellevue Hospital.—A vacancy having occurred by the resignation of one of the Junior Assistants of this Hospital, notice is given that the Examining Committee will meet, June 21st, to examine Candidates. Applicants are requested to apply to Dr. ISAAC E. TAYLOR, 18 West 20th Street.

## To the Medical Profession.—Winches-

TEE'S genuine and chemically pure preparation of Hypophosphites of Lime and of Soda, made from the formula of Dr. John Francis Churchill, of Paris, for the prevention and cure of Consumption; also for Nervous Diseases, Debility, Scrophula, Bronchitis, Asthma, Marasmus, Rickets, Anæmia, and Derangement of the Nutritive Function.

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DR. CHURCHILL'S TREATISE on the "IMMEDIATE CAUSE AND THE SPECIFIC TREATMENT OF PULMONARY PHthisis AND TUBERCULAR DISEASES," translated from the French, will be mailed without charge to Physicians who may request it. It is a work of very great interest to the Profession, setting forth the merits of the new method, with the results in the cases reported by the authority of the Academy of Medicine and Sciences, Paris.

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I prepare the Jelly either from the white American, or from the light-brown Norwegian Cod Liver Oil.

QUERU'S PATENT JELLIFIED CASTOR OIL, is strongly flavored, and very easily taken, obviating the offensive greasiness of the Oil. It does not cause constipation after use. It is a very desirable purgative for children, who take it with pleasure.

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## TO THE MEDICAL PROFESSION.

HAVING devoted my time and attention to the treatment of spinal diseases for the last six years, examining closely the results that have followed, I am now prepared to show that a cure in Pott's disease of the spine may not, in all cases, necessarily consist of curvature, as is generally maintained; that the future progress of the curvature may generally be arrested from the time treatment is commenced, and in case of a recent character a cure effected with the curvature nearly if not completely removed, by appropriate mechanical appliances principally, to the entire exclusion of setons, issues, or any other counter-irritant, or even restricting the patient to the recumbent position.

Those members of the Profession who may favor me with a call at my office, either at 31 Cooper Institute, New York, or 215 Washington Street, Boston, can fully inspect my mode of appliances and manner of treatment, and at the same time be referred to many cases which have been successfully treated.

I beg to refer to the following distinguished practitioners:

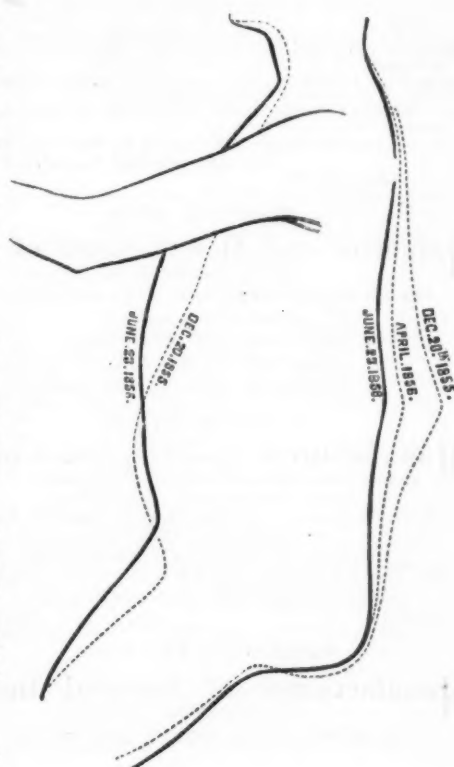
Henry J. Bigelow, M.D., Prof. of Surgery, Harvard University; George Hayward, M.D., Ex-Prof. of Surgery, Harvard University; Winslow Lewis, M.D., Boston, Mass.; J. V. C. Smith, M.D., Boston, Mass.; John W. Warren, M.D., Boston, Mass.; Willard Parker, M.D., Prof. of Surgery, College of Physicians and Surgeons, New York; John T. Metcalf, M.D., Prof. of Institutes and Practice of Medicine, University of New York; Stephen Smith, M.D., Surgeon to Bellevue Hospital, New York; George Marvin, M.D., Brooklyn, N.Y.; H. I. Bowditch, M.D., Boston, Mass.; Samuel W. Thayer, Jr., Prof. of Anatomy in the University of Vermont.

The engraving is a description of a case which I was called to attend in December, 1855: Boy nine years old, son of Dr. —, New Bedford, Mass. Scrophulous diathesis; extremities powerless; form emaciated. The adjoining are the appearances presented by the spine at various dates of my attendance.

Treatment.—Efficient support to the spinal column. Galvanism applied by friction with the hand. Complete relief from pain on the application of the apparatus. Rapid recovery. The slight deformity of the spine yet existing in the plate, has since completely disappeared.

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## University of New York Medical

Department. Session, 1860-61.  
The Session for '60-61 will begin on Monday, October 15, and will be continued until the 1st of March.

### FACULTY OF MEDICINE.

REV. ISAAC FERRIS, D.D., LL.D., Chancellor of the University.  
VALENTINE MOTT, M.D., LL.D., Emeritus Professor of Surgery and Surgical Anatomy, and Ex-President of the Faculty.  
MARTIN PAINE, M.D., LL.D., Professor of Materia Medica and Therapeutics.  
GUNNING S. BEDFORD, M.D., Professor of Obstetrics, the Diseases of Women and Children, and Clinical Midwifery.  
JOHN W. DRAPEL, M.D., LL.D., Professor of Chemistry and Physiology, President of the Faculty.  
ALFRED C. POST, M.D., Professor of the Principles and Operations of Surgery, with Surgical and Pathological Anatomy.  
WILLIAM H. VAN BUREN, M.D., Professor of General and Descriptive Anatomy.  
JOHN T. METCALFE, M.D., Professor of the Institutes and Practice of Medicine.  
J. W. S. GOULEY, M.D., Demonstrator of Anatomy.  
J. H. HINTON, M.D., Prosecutor to the Professor of Surgery.  
ALEXANDER B. MOTT, M.D., Prosecutor to the Emeritus Professor of Surgery.

Besides daily Lectures on the foregoing subjects, there will be five Cliniques, weekly, on *Medicine, Surgery, and Obstetrics*.  
The Dissecting-Room, which is roofed and abundantly lighted with gas, is open from 8 o'clock, A.M., to 10 o'clock, P.M.  
A fee for a full Course of Lectures, \$105; Matriculation fee, \$5; Graduation fee, \$30; Demonstrator's fee, \$5.

## Medical Institution of Yale College.

The Course of Lectures for 1860-61 will commence on Thursday, September 13th, and continue four months.

BENJAMIN SILLIMAN, M.D., LL.D., Prof. Emeritus of Chemistry and Pharmacy.  
ELI IVES, M.D., Prof. Emeritus of Materia Medica and Therapeutics.  
JONATHAN KNIGHT, M.D., Professor of the Principles and Practice of Surgery.  
CHARLES HOOKER, M.D., Professor of Anatomy and Physiology.  
WORTHINGTON HOOKER, M.D., Professor of the Theory and Practice of Physic.  
BENJAMIN SILLIMAN, JR., M.D., Prof. of Chemistry and Pharmacy.  
PLINY A. JEWETT, M.D., Prof. of Obstetrics.  
CHARLES A. LINDSLEY, M.D., Prof. of Materia Medica and Therapeutics.

LECTURE FEES, \$63 50. Matriculation, \$5. Graduation, \$15.

CHARLES HOOKER, *Dean of the Faculty.*

NEW HAVEN, May, 1860.

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JAMES R. WOOD, M.D.,

LEWIS A. SAYER, M.D.,

STEPHEN SMITH, M.D.

Wade and Ford beg leave to call the attention of the faculty to the following notice of this Case of Instruments in the May number of the *New York Journal of Medicine*, page 427:

"A NEW AND COMPLETE CASE OF SURGICAL INSTRUMENTS.—The practitioner of surgery not infrequently has need of an operating case which, in a compact form, embraces the instruments necessary for any and all operations. To the country practitioner especially, would a case of instruments thus selected, be a valuable acquisition. Such an operating case has recently been prepared by Messrs. Wade and Ford, 85 Fulton Street, New York, under the direction of Dr. James R. Wood, combining in a single case of moderate dimensions, instruments and apparatus adapted to every emergency in which a surgeon can be placed."

We have recently perfected Dr. Lewis A. Sayer's Improved Instrument for Morbus Coxarius, under his directions, and will, if requested, forward directions for measurements necessary for a perfect fit.



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"Its construction is simple, and its execution is beautiful. All who possess it concur in bearing practical testimony to its *superiority in comfort and utility.*"

"VALENTINE MOTT, M.D.,

"Prof. Surg., N. Y. University, N. Y."

"I consider it the best invention I have seen, the most useful, and the least distinguishable from the natural limb."

"G. J. GUTHRIE, Esq.,

"Ex-President of the Royal College of Surgeons, London."

The construction of this limb is universally conceded to be concisely anatomical and simple in the arrangement of every part, and perfectly natural in its symmetry and action.

It admirably combines lightness to the fullest extent compatible with utility and comfort, with strength and reliability.

The knee, ankle, and toe-joints, as constituted, are a perfect counterpart of those of the natural leg, possessing the ball and socket form, and a natural *gingymoid* or hinge-like action, with a strength of union which never fails, and the least possible amount of friction, seldom requires lubrication. The tendons, of the strongest and reliable material, perfectly represent those of the natural knee, ankle, foot, and toes, in action, life-like elasticity and reliability at a given point, enabling the artificial leg to gain the same distance for the natural leg in walking as the natural one does for the artificial one, without halting.

Its exterior is beautifully flesh-colored, workmanship perfect, and to its exceeding lightness great strength is imparted by the peculiar quality and mode of covering, which contracts and bands every part tightly, and enables the wearer to keep the limb in a satisfactory condition, without oft-repeated coverings.

During the thirteen years which this mechanism has been so generally sought for and used by more than four thousand persons, it has been thoroughly tested and proved by the very best, most intelligent, critical, and experienced judges, to be all that is claimed for it in naturalness, elasticity, lightness, strength, utility, reliability, and the greatest durability, and to possess every quality and action essential and desirable in an artificial limb, to render it a perfect counterpart to the natural limb in every place, position, and vocation, in sitting, standing, walking, or laboring. Every class, age, and sex of the community is represented in the use of this limb, in the greatest usefulness, pride, comfort, and satisfaction, including those of the most laborious lives.

## ARTIFICIAL FEET, &c.,

For limbs shortened by hip disease, and other causes; a new, natural appearing and acting device, both light and strong, dressing and serving the same as the natural foot; an invaluable substitute for the cumbersome and uncouth cork shoe and stirrup, by Dr. Hudson. This contrivance is greatly admired and estimated by those whom we have treated by its application, for its utility and comfort, in enabling the wearer to obtain the same distance with it as with the natural leg, and for its naturalness in dress.

Address Dr. E. D. HUDSON, of PALMER & Co.,

Clinton Hall, Astor Place, New York.

In the Press,

## Manual of Human Histology. By

C. MOREL, Professor at the College of Strasbourg, translated and adapted to the wants of the Medical Student by W. H. VAN BUREN, M.D., Professor of Anatomy, University Medical College. 1 vol 8vo, with 25 plates.

BAILLIERE BROTHERS, 440 Broadway, N. Y.

## Original Lectures.

### CLINICAL LECTURE ON SYPHILITIC DISEASE OF THE LARYNX.

DELIVERED AT THE NEW YORK HOSPITAL.

BY

WM. H. VAN BUREN, M.D.,

SURGEON TO THE HOSPITAL.

GENTLEMEN:—In our last public visit you remember we examined several cases of syphilis, and that there was one patient to whom I called your attention for a moment, who wore a tube in his trachea. That case belongs to a very interesting class, which is, perhaps, too much neglected, and I have thought it worth our while to spend a few moments in studying its history, and the character of the affection of the larynx which rendered the insertion of the tube necessary.

This affection is known by the name of syphilitic disease of the larynx. It is one of those forms of syphilis which, happily for humanity, is rare, but still it is not uncommon to find in a hospital of any size, one or two men as nurses, wearing these tubes. I remember very distinctly the case of a nurse in La Charité Hospital, of Paris, twenty years ago, who had worn the tube for a number of years.

The term laryngitis is applied correctly to purely inflammatory affections. The disease, however, now under consideration is not an inflammation of the larynx, but is the result of the manifestation of syphilis in that part of the organism.

In order that you may recall all the features of this case I will read an abstract of it, which I have received from my colleague, Dr. Markoe.

JOHN BARBER, *et al.* 35, English seaman, admitted to the New York Hospital, Oct., 1859, with syphilitic sore-throat and laryngeal disease. Had chancre six years ago, followed by secondary symptoms, amongst which was sore-throat; which has since then recurred six or seven times, but the larynx was not involved until the last attack in 1858, for which he was treated in the Hospital; he had then hoarseness and tenderness of the larynx on external pressure, which yielded to anti-syphilitic treatment, and he was discharged, apparently cured, in January, 1859. In about nine months he was readmitted with his present attack, which, like the former ones, was characterized by ulceration of fauces, with hoarseness, pain, and tenderness about the larynx, cough, mucous expectoration, and occasional paroxysms of dyspnoea. The attack was more severe than any of his previous ones, but it gradually yielded and he assumed the duties of a nurse in the Hospital; treatment employed: mild mercurials, cinnabar fumigations, iodide of potassium. About the 1st of February, the throat was again attacked, and still more severely, by reulceration of pharynx, hoarseness, dyspnoea, and extreme tenderness of larynx.

On examination by the finger the epiglottis felt, "irregular, contracted, and thickened." On February 8th, the following was the note taken of the case: "Patient cannot lie down through dyspnoea; expiration seems to be effected with more difficulty than inspiration; expectoration very copious—of viscid muco-purulent matter, and effected with much pain; deglutition excessively difficult—can swallow fluids only."

Under the steady and cautious use of the remedies already mentioned these extreme symptoms yielded during the following week, and the patient's condition improved somewhat, his gums being distinctly sore from mercury at the time of the amendment. But the improvement was not progressive; he still suffered from frequent paroxysms of

dyspnoea, relieved by copious expectoration; the amount of this latter was excessive; his pulse continued above one hundred, with much emaciation and debility, and great difficulty in swallowing; lungs free from disease. In this condition the operation of bronchotomy was decided upon with the view simply of facilitating the function of respiration, and, by placing the larynx at rest, of contributing to its restoration. The operation was done on the 20th of February (by my colleague Dr. Markoe, who was then on duty, and to whose note of the case I am indebted for the facts just stated). A double canula was introduced through the crico-thyroid membrane.

The immediate consequences of the operation were most favorable. Expectoration diminished, together with the constant and annoying hawking, spitting, and coughing; breathing entirely free. Capacity to take solid food returned in a few days, and sleep was undisturbed. On the 27th his pulse had fallen to 90 (from 120), and on the 9th of March he is reported to be gaining rapidly, to have lost his phthisical look, and to be growing fat.

Now, gentlemen, you have the case before you. From the last note, March 9th, to the present day (May 25th), he has been doing perfectly well. He breathes entirely through this double canula. The larynx being, as it were, thrown out of gear, the man cannot speak unless he closes the opening into the trachea and throws the column of air past the vocal cords, which, in consequence of the construction of the tube, can easily be done.

The wound through which the tube is lodged in the trachea is very apt to close when the instrument is left out any time; two hours is sufficient to make the granulations which surround the opening to contract sensibly, and if left out for twenty-four hours it might be impossible to return it.

I remember one patient upon whom I operated twelve years ago, in Bellevue Hospital, for this same disease. One day the House Surgeon, having removed the tube for the purpose of cleaning it, was suddenly called from the ward to attend an obstetrical case, and found it impossible for him to return immediately. In less than two hours after he was sent for in great haste, with the intelligence that the patient who had been thus left was dying. On arriving in the ward he found that the wound had contracted to such an extent, as almost to prevent his breathing; the face was dusky, the lips livid, and there were all the symptoms present of impending suffocation. The Dr. attempted to reintroduce the tube, but found that it was impossible. I arrived about that time, having been sent for in great haste, and with the aid of a probe-pointed bistoury succeeded in replacing the tube. As soon as this was done, the patient breathed freely, the livid hue left his countenance, and he was restored to his former comfortable condition.

In making a few remarks on this case, I wish to discuss, first, the pathology of the disease; second, what are the chances of an ultimate cure, and, finally, what is the value of the operation of bronchotomy in this condition.

As to the nature of the affection, it is properly termed syphilitic disease of the larynx. It is a disease which is not treated much of in text-books, and consequently to the mind of the student its character is apt to be left in a state of obscurity. It is for this reason that I have asked you to study the disease with me this morning.

Syphilis chooses the throat as one of its favorite localities. We all know that sore throat is very apt to occur after an infecting chancre; that in many cases it is either persistent or is very likely to return. We know also that such affections of the throat present themselves in every phase, from a simple erythematous blush to extensive and destructive ulcerations. We have frequently seen this diseased condition occupy every part of the fauces, sometimes extending into the Eustachian tubes, producing deafness, or again perforating the velum, and not unfrequently causing it to adhere to the back of the pharynx. I had under my care a



case in the adjoining ward, in which the *velum pendulum palati* was adherent to the back part of the pharynx in such a way as to cut off all communication between the mouth and posterior nares. The breath had literally "departed from his nostrils," and consequently he lost the power of smell.

I refer to this case merely to show how important functions may be interfered with by the ravages of this destructive disease.

This same disease of the throat is liable to extend and involve the larynx, affecting in succession the mucous membrane of the epiglottis, and of the arytenoid cartilages, and attacking the *chordæ vocales*, in which case there is alteration of the voice present, or, narrowing of the chink of the glottis, with obstruction of respiration. This affection of the larynx, then, is identical in character with that of the throat, by which it is almost invariably preceded. The fact is one of sufficient importance to warrant its reiteration, viz.: that you rarely find syphilitic laryngitis occurring before, or unaccompanied by, ulceration of the throat.

Now, in reference to the forms that the disease puts on. You may see it presenting itself with simple hoarseness of voice (*vox rauca*), which is a symptom somewhat characteristic of syphilis; then again, it may be nothing but an ordinary catarrh of the membrane, and this is its mildest form. If the patient has the disease sufficiently developed in his system, it will present itself either in permanent thickening of the mucous tissue, or advance to positive ulceration. These ulcerations are liable to occur in any part of the surface of the larynx, and they follow the general law of syphilitic ulcerations in other parts of the body, concerning the characters of which you have had abundance of opportunities to learn. We have here upon the table an instance in which the epiglottis has been entirely destroyed by this disease.

I will mention, in passing, that a loss of this part (epiglottis) does not interfere with deglutition. There is a specimen in the museum of Dr. Mott, in which the epiglottis was found wanting at the post-mortem examination, but in which during the life of the patient there was no symptom that led to the suspicion of such a deficiency.

These ulcerations may extend from the larynx unto the trachea, bronchi, or even into the lung tissue itself. These facts are pretty well substantiated by the recent researches in Germany and France, more especially by Virchow of Berlin, Depaul, Diday, and Gubler.

It is probable that as our attention is directed more and more to this subject, it will be found that there are certain forms of bronchitis, if not pneumonia or phthisis, that have their origin in alterations depending upon the syphilitic poison. This is a fact that has been in a measure proved by Virchow, one of the greatest pathologists now living, and whom we should consider, from the rare opportunities he has of investigating the disease, as the highest authority upon the subject.

Syphilis, as I remarked before, prefers certain localities to others—thus upon the skin we notice eruptions, most frequently at the roots of the hair, around the face, and in the neighborhood of the genital organs. In like manner it has its points of preference upon the mucous membrane, and is most frequently met with in the throat, while in the intestinal canal it is very rarely seen, except at the lower end of the rectum.

In regard to the cause of these eruptions or ulcers, I can only say that they seem to be the result of an effort on the part of the economy to eliminate a poison; the secreting glands being irritated to a greater or less degree in consequence. The striking tendency of these eruptions is to run into ulcerations; they, however, are not of a phagedenic character, yielding readily to the anti-syphilitic treatment. Neither do they involve danger to life, unless by their situation they interfere with the function of some vital organ. In connexion with this tendency to ulceration, there is an effusion of a certain material which is as characteristic of syphilis as are tubercles of phthisis. I refer to the *gummy tumor* of the French. This peculiar exudation is deposited

under the skin in masses, going to form papulae, elevations of greater or less size, even entering into the constitution of soft nodes. These deposits are not unfrequently met with in the substance of the tongue, and Ricord refers to one situated in the substance of the heart itself. This, then, is one of the peculiarities of syphilis.

The worst form of syphilitic laryngitis is that in which not only the mucous membrane but the perichondrium is the seat of the disease. The cartilage of course dies, and if the extent of such destruction is by any means considerable, the case must terminate fatally. The existence of this disease is made out without difficulty, from the odor of the breath, which is quite peculiar, being of even a more rancid odor than that which emanates from necrosed bone.

In the case that I alluded to as having been operated upon some ten years ago in Bellevue, there was an exfoliation of bone from the back part of the cricoid cartilage which of course had become ossified. The cartilages of the larynx are, as you know, liable to ossification, and true bone may be found in the posterior portion of the cricoid cartilage at any time after the twenty-fifth year.

In regard to the diagnosis of syphilitic laryngitis. There are certain diseases of the larynx which may be mistaken for syphilitic disease, but I have alluded to one fact, that if remembered, will always lead to a right conclusion. It is this: You cannot have syphilitic disease of the larynx except the throat is the part first affected. This fact can generally be determined by an inspection of the part. Whenever you have cough with laryngeal trouble, and syphilitic antecedents, there can be no difficulty in arriving at a proper conclusion. There are, however, certain forms of disease which may give rise to some doubt in your mind. I allude more particularly to the disease known as *phthisis laryngea*. You know, in the latter stages of the disease, that phthisis is very apt to affect the larynx in consequence of the irritating quality of the material expectorated; this, however, is only a concomitant ulceration, and has nothing to do with the subject in hand. The true laryngeal phthisis was first described by Porter of Dublin, who considers it an alteration of the cartilage of the larynx, by means of which death of the parts takes place, giving rise to the formation of abscess, attended with difficult breathing, pain in deglutition, hectic fever, and the like. Generally speaking, the breath gives the odor of dead cartilage, the thickening around the larynx, and also the presence of an abscess behind is quite characteristic. This disease, however, is very rare, occurring in middle-aged persons; generally follows some catarrhal affection; occasionally it may be brought on as the result of violence. Sometimes the antecedent history is all you can rely upon in coming to a determination.

With regard to the means of examining the larynx, there is a word to be said:—When the epiglottis or upper opening of the organ is affected, you can often, with your finger, feel the lesion. This is one of those little pieces of mechanical dexterity that you must accustom yourselves to, and it is one of those accomplishments which can be acquired only by practice. A very good plan is to practise palpation upon the cadaver in the absence of other opportunities. Another means of throwing light upon these affections is the use of the *laryngoscope*. I hold in my hand one of the varieties of a form of instrument which is of a great deal of use. Here is a mirror pierced through its centre by a small hole, and here are several steel plates attached to handles. The patient is placed with his back to the light, and you in front of him look through the opening in the centre of the mirror at the throat, which is illuminated by the reflected light. The parts around the top of the larynx are reflected on the surface of the steel mirrors, which should be dipped in warm water before using, to prevent cloudiness from vapor.

With regard to the prognosis in this disease what have we to say. Can we cure it? That is the great question. All manifestations of syphilitic disease, when advanced to a certain stage, are notorious for their incurability, and the

affections of the larynx are particularly so, for the reason that the parts can never be kept at rest. Consequently, diseases of this part are more fatal than any others.

The treatment of this affection is twofold—in the first place constitutional, and in the second place local. The constitutional treatment is that of syphilis in general. You have heard that treatment recapitulated in a few words in the notes of the case just read, viz., mild mercurials and the iodide of potassium. It may be proper for me here to make a remark in relation to the use of mercury in so-called tertiary syphilis. These symptoms of the disease so designated are undoubtedly in many cases best treated by mercury. But as to the mode of using the mercury, I have a word of advice to give. You must not rely upon the medicine alone to cure the disease; it must be given in such a manner as not to interfere with the nutrition of the individual, otherwise it does more harm than good. To this end mild mercurials, fumigations, inunctions, and the like are resorted to, that our patients may grow fat at the same time the disease is being cured. Syphilis is a curable disease, but we don't know when it is cured. The treatment must be chronic to cure a chronic disease; in some cases not giving up the persevering use of these milder mercurials inside of 18 months or 2 years. If patients die from this disease, it is either from neglecting themselves, or, which God forbid, by the neglect of the surgeon in attendance.

Fumigations by cinnabar is an old remedy, and were it not for the irritation that it produces in most cases it would be a very good one. I have substituted instead of this remedy the metallic mercury, calomel or black oxide. Each one of these, I think, possesses all the good qualities of the cinnabar, but without any of its unpleasant effects.

Finally, of what advantage is bronchotomy. The patient before us answers that question, I think, satisfactorily. It can assist you by enabling the patient to breathe without his larynx, by quieting that larynx so that your mercurial administration may cure the ulcers. In this way it will prevent the death of your patient by an interference with the functions of that vital organ. Suppose we had treated the case never so skillfully without that tube. What would have been the result? He is now so situated that we can treat him at our leisure. He may not be able to remove the tube even after the disease is entirely cured, inasmuch as it is possible that there may be some permanent obstructions higher up, the result of the contraction of cicatrices. It depends then upon the extent of the lesions in this man's larynx whether he shall be able to dispense with the tube or not.

We ascertain if the larynx is permeable to air by directing him to place his finger over the mouth of the canula for a few minutes at a time. The next step is to insert a cork into the tube; let it remain at first half an hour at a time, and cautiously extend the time to 3 or 4 hours; and finally when he can tolerate its presence for 24 hours at a time, the whole instrument can be removed with a good deal of certainty that no unpleasant results will follow. As bearing particularly upon this point, I cannot resist the temptation to refer to a case of membranous croup in a child 3 years old, in which I have very recently performed the operation of tracheotomy, as a last resort to prevent suffocation. Subsequently to the operation the disease did not extend, as it is so apt to do, into the bronchi, consequently the child recovered. One week after the operation the cork was worn in the canula all day, and on the following day it was removed altogether, in 3 or 4 hours after which the opening closed so as to compel the air during respiration to escape by the natural passage.

This, gentlemen, is all I have to say in relation to syphilitic laryngitis, and if I have succeeded in so interesting you in this subject that you are led to study the disease, I shall have accomplished my object.

## Original Communications.

### FISTULOUS ULCER IN FRONT OF THE LARYNX.

BY JOHN WATSON, M.D.,

SURGEON TO THE NEW YORK HOSPITAL.

THE facts connected with the two following cases, relate to a local ailment not often recognised by surgical writers; an ailment apt to be misunderstood, and one which, even when properly recognised, has hitherto not usually been found amenable to treatment.

*Case First.*—On the 6th of April, 1838, I saw in consultation with a gentleman of considerable surgical experience, a young lady, Miss C., about twenty years of age, who for the previous two or three years had been troubled with a papillary ulcer in front of her neck immediately over the thyroid cartilage, and from the centre of which there had been a continual weeping of a glutinous transparent colorless fluid, like inspissated synovia. Several attempts had been made by the gentleman in attendance, and by others, to close this ulcer, but without effect. Milder means proving of no avail, the ulcerated integument had been excised, under the hope that a newly exposed surface in the healthy skin might take on the process of cicatrization. But after the wound had contracted to a small point, the glutinous discharge, which had not been arrested, continued to keep the parts from closing. Again a second and more severe operation had been undertaken, in which the integuments for a wide space around the ulcer were excised, and the edges of the wound were drawn together by suture, so as to favor union by the adhesive process. The only effect of this measure was to leave an unsightly transverse cicatrix, which greatly disfigured the exposed surface. When I first saw the patient, the ulcerated opening in the centre of this cicatrix was hardly large enough to admit the point of a delicate probe. But after penetrating through the orifice, the instrument slipped readily onwards for about an inch under the integuments, in the median line, upwards in front of the thyro-hyoid ligament, to the border of the os hyoides, where it rested. On withdrawing the probe and grasping the parts along which it had passed, I could feel beneath the skin a delicate cord-like track of induration, such as might result from the indurated parietes of a narrow fistula.

After some deliberation, seeing that the true character of the case had not hitherto been appreciated, and bearing in remembrance that I had often cured obstinate fistule in other parts of the body by injecting them with corrosive sublimate, I advised the gentleman in attendance, first, to inject the fistulous track with pure water, so as to cleanse it, and then to throw in, through a delicate canula introduced to the bottom of the fistula, as much as the parts would contain of the following solution:

R Muriatis Hydrargyri  
Muriatis Ammoniac, aa grs. v.  
Aque pure ʒi. M.

It is sufficient to add that a single application of this solution arrested the glutinous discharge, and led in a few days to the permanent cure of the fistula. I last heard from this young lady on the 1st of July, 1839. There had been no return of the disease, her health was good, and she was then preparing for her approaching marriage.

*Case Second.*—On the 17th of May, 1859, Mary Kelly, aged 17, entered the N. Y. Hospital, with a minute ulcer in front of her neck, over the thyroid cartilage, giving issue to a glutinous discharge corresponding in all respects with that observed in the previous case, and surrounded by a rugged and irregular cicatrix about an inch wide, the result of escharotic applications that had, among other

means of treatment, been employed to no purpose. The discharge in this was more glutinous than in the former case, and when not frequently washed off, would form a thick crust over the ulcerated surface. The fistulous track would not admit an ordinary probe. I was obliged to employ a delicate gold probe intended for the puncta lachrymalia, in order to enter it. But the instrument, as in the other case, after passing the orifice, readily reached the anterior border of the os hyoides, passing in as before, through a track in the median line, somewhat over an inch in length, and the parts here, when grasped, giving the same feeling of cord-like induration.

After dilating the fistula by the use of probes of various sizes, the same course of treatment was employed as in the other case. The house-surgeon, however, mistaking my directions, at first employed a solution of only two grains of corrosive sublimate to the ounce of water. With this he injected the fistula several times with no apparent benefit. But on increasing the strength of the solution to four grains, a single injection arrested the oozing, and in the course of a few days effected a permanent cure of the fistula.

While recording these facts, I have some obscure recollection of an earlier case of the same ailment, the particulars of which I cannot now recall. I have since heard of a recent instance of the same sort, in which the gentleman in charge had been baffled in his efforts to effect a cure. And on mentioning these circumstances to my friend, Dr. A. H. Stevens, he remarked, that they reminded him of similar cases which, many years ago, had given him much embarrassment.

The rationale of these cases would seem to be, that the first point of diseased action is in some minute bursa, or cyst, near the anterior border of the os hyoides, and that the fistula is first established, and afterwards kept patulous, by the glutinous discharge secreted there.

I have not attempted a minute inquiry into the history of this ailment, as given by the surgical writers of England or our own country; but in the few of their works to which I have referred, I have found little or nothing satisfactory. So far as I am aware at present, we owe the first allusion to this disease to Boyer, who appears to have met with two cases of it, which he treated unsuccessfully by the knife and escharotics. He speaks of it as an encysted tumor forming between the os hyoides and the thyroid cartilage, containing a viscid yellowish fluid, and subsisting a long time without acquiring any considerable size, or causing any embarrassment, but disfiguring the neck, especially of females. [*Maladies Chirurgicales*, tome vii., p. 39; Paris, 1834.] In the *Eléments de Pathologie Chirurgicale*, prepared under the supervision of M. Nélaton, vol. 3me, p. 383, I find an allusion to the same ailment, apparently derived from Boyer, but with some additional details derived from the researches of Bèclard and M. Malgaigne, especially in reference to the normal existence of two bursæ in the locality occupied by this fistula; the one, over the projection of the thyroid cartilage; the other, somewhat above this, in the thyro-hyoidean space. The writer in question is disposed to believe that the source of the glutinous discharge is some mucous follicle near the base of the tongue, founding this opinion on what he assumes to be the fact, that the discharge is rather of a mucous than of a serous character. The truth, however, is, that the discharge is such as we often meet with in openings communicating with the joints, and such as I have often seen issuing from diseased bursæ. He speaks of treating the disease by iodine injections.

Dr. Gross, in his recent systematic work, while treating of injuries and diseases of the neck, alludes to what he calls the "*Synovial Bursa*," in the following words: "An encysted tumor sometimes forms in the upper and fore part of the neck, taking its rise in the synovial sack situated between the hyoid bone and the notch of the thyroid cartilage. This sac, which, in its natural state is hardly a few lines in diameter, may, in consequence of inflammation,

acquire the volume of an egg, if not of a small orange. It is of oblong shape, elastic, slightly translucent, and filled with a thin, serous, oily, or viscid fluid. The superincumbent skin is healthy, and the swelling is entirely free from pain. The treatment is by seton, injection, or incision, as in encysted tumors in other parts of the body." [*System of Surgery*, vol. ii. p. 545.]

Tumors such as are here described, I have myself occasionally met with. I have not considered them pathologically identical with the disease giving rise to the fistulous ulcer. But whether both may or may not be looked upon as different phases of the same malady, I will not at present undertake to determine.

NEW YORK, May 28th, 1860.

## ANÆSTHESIA AND ANÆSTHETICS.

BY EDWARD R. SQUIBB, M.D.,

OF BROOKLYN, N. Y.

THE condition of insensibility to pain belongs exclusively to the brain proper, or to that part of the nervous system which provides for sensation and voluntary motion; and is effected, when not the result of mechanical injury, invariably through the agency of the circulation. It therefore follows upon this, and upon the circumstance that the nervous centres of organic life exercise no primary function of ordinary sensation or voluntary motion, that the special agents resorted to for anæsthetic purposes should not only be directed especially to the sensorium, but should be diverted as far as practicable from the remaining portions of the nervous system, in effect. But, the circulation carries the anæsthetic agent everywhere, and with the elements of vitality and molecular reproduction must convey and distribute this powerful agency also; and hence the special agent for effecting anæsthesia should not only act directly, promptly, and transiently upon the sensorium, but should be, as far as possible at least, innoxious elsewhere. In short, it should suspend the functions of the sensorium without liability to interference with any other organ or function.

Such an anæsthetic effect is produced perhaps in the greatest degree of perfection by a certain amount of concussion of the brain, which sometimes results from accidental violence; and the effect is most perfect here, because it is produced directly upon the brain without any contamination of the circulation with foreign influences; and the circulation thus left free for the performance of its normal functions not only preserves the organic life intact during the temporary abstraction of the presiding sensorial functions, but through its reparative agency quickly remedies the shock, and restores the brain to its normal condition.

The next most perfect anæsthetic effect is that to which a small proportion of persons are susceptible, wherein the sensibility to ordinary impressions of pain or injury is suspended or overpowered through concentric nervous effect. Whenever the balance of nervous power is so disturbed as to reverse the current of the nervous batteries (so to speak), as in the so-called mesmeric condition of certain persons of feeble nervous tone or energy; and in the high degree of nervous excitement to which others are liable through agencies that act altogether from without, the æsthetic functions of the sensorium are altogether suspended, as in catalepsy, or are so impaired that serious injuries are unconsciously received.

The effect, however, in both these classes of cases can never be utilized if from no other cause than because it is independent of the circulation, and all other practical means of production, maintenance, and control. The circulation therefore becomes indispensable as the means of introducing the anæsthetic agent, and of controlling its effect; and the collateral circumstance that the circulation must inevitably carry the agent to parts where it is not



desired, and where it may become noxious, must be taken as a drawback, and a most important indication in both the selection and management of the anæsthetic to be used.

From these circumstances, and inductions taken as points of departure, it is not difficult to deduce the indications in the use of anæsthetics as being, first, to suspend sensation and voluntary motion; and, secondly, to do this with the least possible interference with the functions of organic life. These points admitted, and kept prominently in view, will, with a little reasoning, render the management of anæsthetic agents very simple, and will make the accidents and mismanagements more intelligible and more easily avoided.

These accidents are, first in importance as well as in frequency perhaps, some form or degree of asphyxia. All the vapors used for anæsthetic purposes are irrespirable. That is, they do not contain oxygen in a condition in which it is available in the lungs for renewal of the blood. Just in proportion, therefore, as the vapor is introduced is the normal quantity of air diminished, and the proper oxidation of the blood prevented; and the ratio of this proportion is as inevitable in the effect upon the powers of life as it would be if carbonic acid or water, or any other irrespirable medium was substituted even up to that proportion which produces spasmodic closure of the glottis. It has been not unfrequently noticed, in what the writer believes to be the mismanagement of both the common anæsthetics, that the administration has commenced with a proportion of the vapor so large as to produce this spasmodic closure of the glottis. Under such circumstances, if it was possible to keep up such a proportion throughout the struggling of the patient, the spasmodic closure would doubtless be as persistent as it is in drowning. But when from withdrawing the sponge a little, or from the displacement of it in struggling, the proportion of air is increased, the glottis is relaxed again, and the imperfect respiration goes on quickly to a point when, from the undue, sudden, and depressing effect of the anæsthetic on the nervous centres, the glottis no longer responds to the action of the irritant, and the vapor passes freely into the lungs, no matter how strong or how small the proportion of air mixed with it. The pulse and respiration then give the indications to suspend and reapply the anæsthetic, and it becomes a matter of time, endurance, and of management as to how far the powers of life are taxed.

It is, therefore, not a question as to whether aeration of the blood is to be interfered with at all, or not, since some portion of anæsthetic vapor is indispensable, and since that portion must exclude a corresponding portion of the air; but the question is rather, how far the due aeration of the blood may be judiciously and safely interfered with;—or in other words, what degree of asphyxia is justifiable and proper in the management of anæsthetics; and the natural conclusion is as practical as it is logical, namely, that the least possible degree is safest and best, and that the interference should not be hurriedly induced, nor maintained a moment longer than is absolutely necessary.

If suspended animation from the circulation of venous blood in the brain was to be resorted to for anæsthesia, it would be necessary to immerse the patient at intervals in water, carbonic acid, or other irrespirable medium, in order to maintain the condition; and the risk of fatal asphyxia would be here much more apparent, though really not very much more imminent than in the nearly parallel case wherein the irrespirable vapor of ether is substituted throughout a clinical lecture, with the antagonistic stimulant effect of the operation postponed till near the end of a long period of insensibility. The position that the insensibility in ordinary anæsthesia is due to the circulation of unrenewed blood in the brain is, however, only true in part at the utmost, and this introduces another of the accidents that may occur in the management of anæsthetics.

If it were possible to separate the true desirable anæsthetic effect from every vestige of asphyxia on the one

hand, and from all direct interference with the functions of organic life on the other, it would probably be found to consist in a simple specific paralysis of the nervous ganglia of sensation; and the desirable degree of such effect would be that which did not at all overreach the object. By overreaching the object however, whether it be by a too profuse, or a too prolonged use of the agent, the result must be injurious, since suspended function is but one step in the catenation which leads to disorganization and death,—and that step once passed the others may be accomplished insidiously. Such an hypothetical position is, however, only assumed to show that there must be a condition of hyperanæsthesia, or excessive anæsthetic effect,—that such a condition is hurtful and unsafe, and that it should be avoided by skill in management, no matter how safe the agent used may be considered.

That such conditions do not occur without warning through the failing functions of organic life, is the fortunate result of the harmony and dependent action of the nervous centres, and these functions of organic life are commonly and very properly watched, as the means of control in the administration of anæsthetics. But apart from the fact that a most hurtful and dangerous degree of asphyxia may be induced suddenly, and while both pulse and respiration are spasmodically kept up by the stimulus of the first effect of the agent used, there are grave accidents which occur to the centres of organic life, both by reflex action from the brain proper, and by the presence in the circulation of such powerful depressing agents. Blood overcharged with anæsthetic vapors, and particularly when imperfectly aerated and slowly circulated, must necessarily fail of its due impression upon the cardiac and respiratory ganglia, and paralysis of the heart, or muscles of respiration are, therefore, the common fatal accidents of anæsthetic practice.

All these circumstances lead directly to the conclusions, first, that anæsthetics should be given slowly and carefully, with free, unlimited admixture of air, so that there should never be any choking or spasmodic action of the glottis. Secondly, that they should only be given at the time when the effect is needed, and be abandoned the moment the necessity is past. Thirdly, that not only should the pulse and respiration be watched carefully during the whole period of insensibility, and be kept as near the normal standard as possible, but the slightest amount of blueness or lividity should be regarded as an indication of asphyxia, and be promptly responded to by a more free admission of air.

In the choice between the two anæsthetics in common use one or two points are deserving of attention.

Chloroform is much less liable to produce cyanosis or asphyxia, because it is effective in much smaller quantity than ether, and does not therefore displace so much air in the respiratory process. The writer has never noticed any degree of blueness from the use of chloroform, but has often seen it in the use of ether. On the other hand, unless chloroform be given with far more care than is necessary with ether, it is, from its greater efficiency, much more liable to produce hyperanæsthesia, and to paralyse the heart and respiratory muscles. Hence chloroform, under ordinary circumstances, must be considered more dangerous to life, because its greater efficiency and activity, while they render it less liable to produce asphyxia, render it more liable to produce the other accidents of anæsthetic practice. The balance against it is, however, more applicable to its common and indiscriminate use, than when applied with the care and precaution indicated in the foregoing remarks; and there is probably quite a large class of cases in which it cannot judiciously be replaced by any other agent, as, for instance, in parturition; in uremic convulsions of gestation and parturition; and, in short, whenever an intermittent and prompt effect are desirable, and the due precautions can be rigidly observed. In careful practice, with ordinary good judgment and observation, it has in the writer's opinion, the advantage over ether in

every point except the single important one that, in rare instances, it is liable to produce sudden fatal paralysis of the heart.

Ether has been regarded as so safe an anæsthetic, that it is scarcely admitted as susceptible of doing harm; and the impression is very common that it can never endanger life. That either of these propositions can be accepted admits of great doubt.

In the asphyxia from drowning, if the immersion be of short duration, and if the muscular system has not lost its vital tonicity, it is usually only necessary to re-establish the respiration and circulation for a short time, by artificial means, to restore life. If that drowning be prolonged, however, by repeated short immersions, so that the same inefficient condition of the circulating blood be brought about during a half or three quarters of an hour of struggling, and with depressing influences from other sources, as of previous disease or injury, so that the powers of endurance are worn out, and passive exudations are permitted to accumulate and obstruct the pulmonary air cells, the result would probably be very different. A condition of vital depression would be established which might very slowly go either way in the balance between life and death, but which would probably, in case of other coinciding influences, as after a serious surgical operation, ultimately terminate fatally. The partial asphyxia produced by a prolonged etherization is a nearly parallel case under ordinary circumstances; and here, as in other instances, pernicious influences may be masked by the complication and remoteness of the results.

So strongly has the writer's attention been drawn to these circumstances, by seeing and hearing of the profuse and wasteful use of ether, that it is a prominent object of this article to invite the profession to a closer scrutiny and observation of the effects; and if two or three fluid ounces of ether be found to produce a safer and better effect than double that quantity, an important point will have been attained.

The method of administering ether adopted by some close observers is one which appears well adapted to ensure a due admixture of air. A folded napkin is rolled into the form of a cylinder, or truncated cone, and secured at the overlapping edges by two pins. The larger end is made wide enough to cover the nose and mouth, the nose fitting into a notch, where the two edges of the napkin at the widest end fail to overlap. The opening at the small end should be at least one and a half inches in diameter, and the larger the better. If anything be needed to give stiffness and form to this cone, a piece of pasteboard laid between the folds of the napkin before it is rolled up, will accomplish this purpose. This cone is held in the hand of the person who gives the ether, and as a matter of economy it may be removed from the face during each expiration. About two fluidrachms of ether is poured upon the inside of the napkin at a time, and renewed as often as may be requisite.

In the administration of ether for anæsthetic purposes, at least three well-marked stages are commonly observable, and the duration of each varies very much with the temperament of the individual, the condition of the stomach, and the quality of the ether used. One of these stages, namely, that of excitement and delirium, and the only troublesome one, has been hitherto supposed to be shorter in proportion as the ether contained less alcohol; but some very recent observations made by the intelligent House-Surgeon of the New York Hospital, Dr. Weir—though as yet very limited in number—would appear to indicate that the point of maximum, or best effect in this respect, may be overreached, or that a determinate small proportion of alcohol in the ether may be useful. At least, Dr. Weir has been very naturally led to this inference by the effect of giving a small amount of brandy before the anæsthetic; and subsequently by the use of alcoholic ether. He, however, states distinctly, that as yet his observations are not sufficiently numerous to be relied upon. An occasional

accident in the prolonged use of ether, for the mention of which the writer is also indebted to Dr. Weir, is the occasional occurrence of a smart, ephemeral, irritative fever, which follows within twenty-four hours. In view of the circumstance that the local effect of ether is irritant to the extent of producing vesication when confined upon delicate surfaces, it may be easily understood that its application over the large and delicate mucous lining of the bronchial ramifications, throughout an unusually tedious and difficult operation, might produce a transient inflammatory effect. In conclusion, the writer is aware that the character and drift of these remarks are directly at variance with the teachings of some very high authorities, who regard the anæsthetic condition as one of dead-drunkness, and who advise the rapid and copious administration of the ether, in order to reach this condition in the shortest possible time.

It appears to the writer singular, that those who are in the daily habit of making the most delicate distinctions in diagnosis, should fail to discriminate between the effects of poisonous doses of alcohol and the desirable condition in ordinary anæsthesia, since they certainly do not much more nearly resemble each other than the coma of narcotism resembles natural sleep.

BROOKLYN, May 25th, 1860.

#### A CASE OF STONE IN THE BLADDER—HIGH OPERATION—UNSUCCESSFUL RESULT.

BY JAMES R. WOOD, M.D.,

SURGEON TO BELLEVUE HOSPITAL.

THE high or supra-pubic operation for calculus of the bladder is not often practised at the present time, and it is rare that any surgeon selects it in preference to the lateral method. In certain cases, however, it is still preferred by many surgeons as in lithotomy in the female, and in children, while in some cases, as where the stone is very large, the prostate greatly enlarged, or other peculiarity renders the lateral operation difficult or impossible, the supra-pubic method must necessarily be adopted.

In the following case the high operation was decided upon after consultation with my colleagues on account of the existence of a greatly enlarged prostate, and the remains of an old stricture. The notes have been kindly copied from the Hospital Records, by Dr. Eugene Peugnet, house surgeon:

Ward 17, Male Bed 11.—David Gibson, æt. 58: Ireland; weaver; married; temperate in his habits; bad constitution. Admitted Feb. 20th, 1860. (Service of Dr. Jas. R. Wood.)—About four years since patient was treated, in private practice, for chronic cystitis and stricture of urethra. At that time there were two strictures distinctly perceived, one in the membranous portion, and the other in the prostatic portion of the urethra, directly behind the triangular ligament. There was also a false passage situated anterior to the first stricture. The prostate was very much enlarged, measuring about two inches laterally; a No. 5 sound being at that time passed with great difficulty. The urine, which was examined from time to time, contained abundance of triple phosphate, pus, and viscid mucus, together with albumen dependent on the blood. The patient occasionally passed small crystals of triple phosphate, which caused him a great deal of pain, particularly when passing the seats of the strictures. Patient had never contracted gonorrhœa, but in his early youth had been accustomed to ride a great deal upon horseback. At the date of admission his general health was poor. The strictures had been somewhat relieved, and a No. 10 sound could be passed with difficulty, though the patient had still considerable difficulty in urinating, the use of the catheter being frequently necessary. On further examination, a calculus was discovered in the bladder. The prostate measured about three inches laterally. The patient

complained of considerable pain in the small of his back. On analysis and microscopical examination of the urine, it was found to contain pus, mucus, and triple phosphate, together with albumen and blood.

April 7th, 2 P.M.—Patient was put under the influence of an anæsthetic with difficulty, by Dr. J. J. Crane, there being a remarkable muscular rigidity, and the bladder having been injected with  $\frac{3}{4}$  xiv. of tepid water, Dr. Jas. R. Wood, assisted by Drs. Parker, Buck, and C. T. H. Meier, proceeded to perform the high operation for stone. The Doctor first made an incision three inches in length just above the pubes, in the median line, successively dividing the abdominal layers, down to the bladder, and going through the linea alba. The organ being very readily exposed, it was seized with a double hook and drawn downwards by Dr. Meier, the lips of the wound being separated and the peritoneum held back by Dr. Parker. Dr. Wood then cut into the bladder and introduced his finger in order to ascertain the position of the stone, and then extracted it from the bas-fond of the bladder with a small pair of calculus forceps. The stone was about the size of a pigeon's egg. At this stage of the operation a portion of small intestine protruded. They were returned without difficulty. The ruptured peritoneum, together with the transversalis fascia, which was loaded with fat, was secured by two silver sutures, and the wound in the bladder by two more. The external wound was closed and the edges held in apposition by two more silver wires, a compress of lint laid over the wound, and a flexible catheter was then introduced into the bladder and held in its position by tapes. Two grains of opium were then administered and ordered to be repeated every hour with brandy  $\frac{3}{4}$  ss.

4.30 P.M.—Pulse 104. Complains of cold and a good deal of pain and tenderness over the abdomen. Ordered bottles of hot water to be applied to thighs and sides of the patient.

6 P.M.—Pulse 104. Patient feels rather more comfortable.

7 P.M.—Ordered carb. ammoniæ, gr.v., and tr. capsici, grt. xv. every half hour.

8.30 P.M.—Pulse 122, and rallying; skin warm; respirations 24; pupil moderately contracted; tongue moist; thirst; considerable pain; urine passing freely through the catheter.

11 P.M.—Pulse 120; respirations 24; skin warm and moist: tongue coated white; pupil contracted somewhat; a good deal of pain and tenderness; thirst.

April 8th, 4.30 A.M.—Pulse 100; respirations 24; tympanitis well marked; slight pain.

9.30 A.M.—Pulse 133; respirations 36; pupil not so much contracted; considerable tympanitis. Ordered opium gr. ij. every half hour. (The opium taken by the patient up to this time was made into 1 gr. pills instead of 2 grs., owing to a mistake of the apothecary, which is now rectified.)

1 P.M.—Pulse 120; respirations 24; patient is somewhat narcotized; extremities cold.

4.30 P.M.—Pulse 100, and weak; respirations 32; patient is rapidly sinking.

9 P.M.—Patient is unable to swallow his medicines; extremities cold.

April 9th, 3.30 A.M.—Died.

*Autopsy eleven hours after death.*—Rigor mortis well marked; considerable tympanitis. On opening the abdomen slight evidences of peritonitis were found, and some old adhesions between the small intestine and cæcum. A rupture of the peritoneum was found at its reflexion from off the bladder. Two silver sutures had been passed through the peritoneum, which was found to be united. Another and transverse wound of the peritoneum was found at the point where it is reflected on to the abdominal wall, the small intestines having protruded through the larger opening; the bladder was found firmly contracted; there was no extravasation of urine. The coats of the bladder were very much thickened and softened. The kidneys were very much diseased; the right one containing some cysts. Upon opening the left kidney, which weighed

about fourteen ounces, a large abscess was found in its lower portion communicating with the pelvis, and containing an ounce of pus. Within the cavity of the abscess was found a large calculus of triple phosphate. Several small calculi were also found in other portions of the same kidney. The liver was healthy. A few obsolete tubercles were found at the apex of the left lung. The right lung and heart healthy. The prostate measured about three and a half inches, the middle lobe being much enlarged, about the size of the first joint of the thumb, and ulcerated; two false passages in the membranous and prostatic portion on either side of the stricture.

The high operation has at different periods had its special advocates, and has by them been performed exclusively in a sufficient number of cases to give some valuable statistics. We can refer to the following: Maund lost five in forty operations; Côme, nineteen in one hundred; Cheselden, one in seven; Souberville, eleven in thirty-nine. Mr. Humphrey in a statistical article (*Trans. Provincial Med. and Surg. Assoc.*, vol. 17,) has collected one hundred and four cases, of which thirty-one were fatal, or less than one in three. The following table of the comparative results of the different methods of lithotomy from Dr. Gross's recent excellent work on surgery is very instructive:

Methods.	Cases.	Cures.	Deaths.	Proportion.
Lateral operation,	5418	4824	589	1 in 9 $\frac{1}{2}$
Bilateral method,	207	175	32	1 in 6 $\frac{1}{2}$
Recto-vesical section,	83	67	16	1 in 5 $\frac{1}{8}$
Supra-pubic operation,	180	141	39	1 in 4 $\frac{5}{8}$

The supra-pubic operation has now been performed in this city at least ten times, and with results much less favorable even than are given in the above table. By the courtesy of the several gentlemen who have performed this operation, I am permitted to append to my own case brief notices of their cases.

**OPERATIONS BY DR. PARKER.**—*Case 1.*—Mrs. L. æt. 53, married. The stone was large; operation commenced by injecting the bladder with warm water; incision above the pubes, two and a half inches along the linea alba, cutting down to the bladder; opened the bladder with a pointed bistoury, which was followed by such a regurgitation of fluid through the artificial passage, that the assistant was directed to remove his finger from the urethra, and allow the contents of the bladder to escape; introduced the *bresepierre* of Baron Heurteloupe through the urethra; raised the fundus towards the external opening, until I was able to reach it with the tenaculum; incision not being sufficiently free, was enlarged; the finger being introduced, the forceps were readily carried into the bladder, and the stone removed with great ease; operation terminated by closing the upper portion of wound, and leaving lower part open to admit the free escape of urine, or pus, and thus prevent infiltration; patient recovered very rapidly; stone nearly two inches in length, and one and a half in breadth.

*Case 2.*—Miss M., æt. 53, had a large urinary calculus; made trial of lithotripsy; succeeded in breaking off about one drachm; bladder became inflamed, and in about three weeks proceeded to remove the stone by the high operation; patient was put under chloroform; bladder injected with flaxseed-tea; made an incision along the linea alba, and reached the bladder readily; hooked strongly through it by large tenacula, then punctured the bladder with a pointed bistoury, and made an incision about and a half inch in length; easily removed the stone with nasal polypus forceps; upper part of wound was closed with a suture, the lower being left open for the escape of any discharge; result very satisfactory.

*Case 3.*—Mrs. E., æt. 47, had suffered from stone in the bladder, until she could hardly move about; operated according to the plan laid down in the preceding case, and notwithstanding the amount of disease of the bladder, pa-



tient improved greatly, and three months after was comfortable, but had a slight opening above the pubes, from which pus, at times, escaped.

*Case 4.*—A. W., æt. 53, Sing-Sing, symptoms stone in the bladder. Patient, a lawyer, with great nervous development; his system had been greatly overworked in the practice of his profession; had difficulty about the urinary organs for some five years; urine containing pus, blood, and triple phosphate; an examination with a sound revealed the presence of a stone in the bladder; calculus appeared to be encysted; it was removed by the high operation, Dec. 17, 1857. Patient rallied from the effects of the operation, but in 36 hrs. began to vomit, sank gradually, and died Dec. 21 (four days after the operation), from violent, and long continued emesis, caused by inflammation and softening of the stomach, as the autopsy showed. The external wound had healed, no urine came through it, but all flowed by drops from a catheter placed in the bladder after the operation.

*OPERATION BY E. NOEGGERATH, M. D.*—*Case.*—S. B., a healthy child until the age of three, when his parents noticed a change in his generally lively disposition; complained of fatigue in the limbs; wet his bed at night, and even his clothes during the day; several physicians pronounced the disease catarrh in the bladder. When called to the case, child was eight years old, and pitiful to behold; his body reduced to skin and bone, with an expression in his face of long continued and intense suffering. He was constantly wetting his clothes with urine, and supporting his perineum and scrotum with his right hand. This last phenomenon determined me to make an instrumental examination of the bladder, although the skilful physicians who had, in their examination, found no stone, almost satisfied me that there was really no calculus present; after repeated trials, a stone was detected; the high operation was performed in the usual manner, and a very large calculus removed with great difficulty; the boy recovered after suffering from prostatic calculi.

*OPERATIONS BY DR. KRACKOWITZER.*—*Case 1.*—John Nelson, born of healthy parents, July 10, 1857. While a baby a few weeks old, had varioloid; since then, has been often sick with diarrhoea and bronchitis. About the middle of February, 1859, had symptoms of stone in the bladder; in May, masses, like mortar in consistence and color, passed from the urethra. At that time the parents brought him to the German Dispensary, of the City of New York, (132 Canal street), to be treated for catarrhal pneumonia. When he got better of that, under the care of Dr. M. Herzog, he was turned over to the surgeons to be examined for stone. Dr. L. A. Voss found the entrance to urethra blocked up by a substance which, after dilatation of the opening of the urethra, had a cylindrical shape, being about half an inch long, forming a cast of the urethra, of whitish color, resembling mortar. An examination made May 16, with the sound, revealed, without difficulty, a stone in the bladder. All symptoms of pneumonia having subsided, the operation was performed May 22, 1860. The sensation imparted to the touch by gently squeezing the stone, could be compared to nothing better than that of a hard-boiled egg. The patient went on the first three days satisfactorily, but pneumonia set in of which he died.

*Case 2.*—R. C., 18 months old; has suffered from symptoms of stone in the bladder from birth; operation Nov. 19, 1859; closed wound of the bladder with the silver wire sutures; great prostration and vomiting from chloroform; rallied after four hours, but grew weaker in the night, and died ten hours after operation.

*Case 3.*—D. E. Symptoms of stone three years; operation after same method; Dr. Sims applied the silver suture; did well for six hours, then tenderness and swelling of the abdomen; vomiting; great restlessness; rapid, small pulse; died twenty-three hours after operation.

*OPERATION BY HENRY STUART HEWIT, M.D., FORMERLY OF THE U. S. ARMY.*—*Case.*—E. S., aged 19; all the rational signs of stone in the bladder; after mature deliberation, determined to select the high operation; ordinary abdominal section was made; the viscus raised upon the point of the retained catheter was secured by a stout suture passed through its coats; the stone was extracted with the utmost ease; the incision in the bladder was immediately closed by four points of interrupted silk suture, inserted with the aid of a sharp artery-needle; patient made a rapid recovery.

## Reports of Hospitals.

### NEW YORK HOSPITAL.

#### AMPUTATION OF LOWER THIRD OF FOREARM, ACUPRESSURE.

[Reported by ROBERT F. WEIR, M.D., Resident Surgeon.]

The patient on whom Simpson's method of controlling hemorrhage by acupressure, was first practised in the New York Hospital, was a healthy young man, aged 23 years, who had received a short time prior to his admission (March 16th, 1860,) a severe compound fracture of the left metacarpus with considerable laceration of the soft parts, which had been produced by his becoming caught in some machinery. An attempt was made to save the ulnar portion of the hand, where was the least amount of injury, but this, however, failed, the fingers sphacelating. The wound was then left to digest, and attention was directed towards improving his general condition in reference to a secondary amputation, which was performed, April 26th, by Dr. Van Buren, at the junction of the lower and middle thirds of the forearm; the tissues of which were much thickened and cedematous. The method of anterior and posterior flaps of integument with circular division of muscles, etc., by successive incisions, was adopted; the tendons also were drawn out of their sheaths to a moderate extent, and cut off to prevent interference with primary union, in the manner advised by Mr. H. Croskery in *Med. Times and Gazette*, vol. i., 1860, p. 86. Three common Berlin wire wove pins, about two and a half inches in length, and similar to shawl pins, were used; one each, for the radial, ulnar, and interosseous arteries, the latter being secured by a needle passed directly through the interosseous space, but not appearing in the face of the stump, and compressing the vessel against the outer border of the radius; the other arteries being secured. The extremities of each needle being in the cutaneous surface of the palmar flap as the stem of a flower is fastened to the lapel of a coat. No ligatures were applied, and the stump was closed by seven silver wire sutures; some slight oozing occurred the same evening from the outer angle of the wound but ceased spontaneously. Forty-eight hours after the operation, but moderate swelling having ensued, the needles were carefully withdrawn, and on the eighth day the sutures were also removed; union by first intention having taken place throughout the deeper portions of the stump, and but a slight linear ulceration being visible at its periphery. This speedily cicatrized, and the patient was discharged from the hospital May 19th.

#### INCISED WOUND OF WRIST—RADIAL AND ULNAR ARTERIES SEVERED.

[Reported by T. B. WARD, M.D., Acting Resident Surgeon.]

I. S., æt. 37, was admitted April 2d, having received among other injuries in a fight, an incised transverse wound of the left wrist, dividing the radial and ulnar arteries. When first seen by the surgeon he was suffering from the effects of the hemorrhage, which, according to all accounts, was quite profuse immediately after the injury was inflicted. The wound was cleared of clots, both vessels were secured at their proximal and distal extremities, and the lips brought

together loosely in order to court union by second intention, and the whole supported by a dorsal splint on the forearm.

The process of cure was a very tedious one, the granulations for a long time were pale and indolent. This circumstance was no doubt owing to the anæmic condition of the patient, but more particularly to the imperfect establishment of the collateral circulation of the parts.

#### PENETRATING WOUND OF CHEST.

James Fleming, æt 23, New York, was admitted April 29th, at five o'clock A.M., having received his wound in a bar-room scuffle, the instrument used being an oyster knife. The wound is three-quarters of an inch in length, and situated two inches to left of median line of sternum. The first rib is entirely divided across three-fourths of an inch from its sternal articulation. The lung is evidently penetrated, from the fact that air issues freely from the wound. Slight oozing of venous blood at time of admission. Patient is much prostrated, no pulse at wrist, surface very cold, jactitation of limbs, anxious countenance, &c.

*Treatment.*—The heater was applied, reaction was established, and afterwards opiates were administered, but at the end of the second day after, the patient was seized with the symptoms of pleurisy, which terminated in death the following day.

*Autopsy.*—Eighteen hours after death the catheter was introduced into the wound and penetrated to a depth of three inches in the substance of the lung. The pleural cavity was found to contain three and a half pints of serum mixed with blood. The left lung entirely collapsed, and wound found two and a half inches below apex. Strong adhesions around wound; other organs healthy.

#### BELLEVUE HOSPITAL.

##### MALPOSITION OF FŒTUS DETECTED BY EXTERNAL MANIPULATION DURING LABOR.—CEPHALIC VERSION BY THE SAME MEANS, —SUCCESSFUL.

The following interesting and highly practical questions in obstetrical science, have recently been agitated among those devoted to that branch of medicine. 1. Can a mal-position of the fœtus in utero be detected by external manipulation prior to labor? and, 2. Can such mal-position be rectified prior to labor by external manipulation? Some of the leading professors of obstetrics in this country have taken strong grounds in the negative, and several not only denying the possibility of detecting and correcting mal-positions prior to labor, but even questioning the professional honesty of the practitioner who should endeavor to determine by external examination, prior to labor, whether a mal-position existed. The following case, which occurred in Bellevue Hospital, a few days since, under the care of Dr. Barker, is a most important contribution to this subject. We copy the notes of the case, furnished us by Dr. E. B. Barrett, House Physician:

Mary Ann —, æt. 17, born in Ireland, was admitted to the Waiting wards of the Bellevue Hospital March 19th, 1860, in her first pregnancy. On examination, the uterine tumor was very conical, projecting markedly to the right, as well as forwards, triangular in shape, with its transverse diameter greatest. The os uteri was dilated to the size of a quarter of a dollar, and dilatable. The membranes were very full, and projected strongly from the os, and so tense were they that no part of the child could be felt from danger of rupturing them. On the following morning, as the pains had somewhat exhausted the patient from their teasing character, and as little or no progress was being made, an opiate was administered, from which the patient was enabled to obtain some sleep, awaking much refreshed at 12 M. (the 4th.) The pains now increased in force and frequency, but with no result, save the further dilatation of the

os, which was now between two and three inches in diameter. On vaginal examination no part of the child could be felt without rupturing the membranes; by palpation the previous conjecture, viz. that a transverse presentation existed, was rendered nearly certain.

Dr. Barker came to pay his daily visit at this juncture, and concurring in the opinion that the child presented transversely, decided on immediate interference. Accordingly the patient was brought under the influence of chloroform. Dr. Barker again examined the tumor more carefully, both by palpation and "per vaginam." Through the external walls the head could be felt in the left iliac fossa, above the pubis. The pelvic extremity of the fœtus was in the right iliac fossa, and the curve of the dorsum could be traced strongly projecting forwards. By a vaginal examination the os was found dilated to the diameter of about three inches, soft and dilatable, with a very large and projecting bag of waters. The presenting part of the fœtus could not easily be felt through the bag of waters, and no force was used for fear of rupturing the membranes; but the deduction, from the external and vaginal examination, was, that the right shoulder was the presenting part at the superior strait. Dr. Barker therefore decided to attempt cephalic version, in preference to the ordinary method, and he at once proceeded to operate, in the presence of several members of the medical staff of the hospital. The patient being brought to the edge of the bed, in the approved position, he first manipulated by attempting to elevate the pelvis of the fœtus with his left hand, and to depress the head with the right, acting only when it was found that the uterus was not contracting. Finding that he had essentially changed the position of the fœtus, the right hand of an assistant was placed to make strong pressure over the left iliac fossa; he (Dr. B.) still elevating the pelvis of the fœtus with his left, introduced into the vagina two fingers of the right, and during the time of uterine contraction ruptured the membranes, when the waters escaped with great force and abundance. The head could now be felt in the superior strait in the left occipito iliac position. The administration of chloroform was now discontinued, in the hope that the uterus would complete the delivery unassisted. Slight pains, with little progress, followed for fifteen minutes, and as the fetal heart was beating somewhat feebly, it was deemed necessary to apply the forceps. The forceps being applied, a male child, weighing eight pounds, was extracted in a partially asphyxiated condition. Respiration was established in a short time, however, and it is now a perfectly healthy child. The placenta came away in five minutes, with no more than the usual amount of hemorrhage; the perineum was not lacerated, and the patient but little more prostrated than is usual after natural labor. The patient proceeded to a rapid convalescence, with no unfavorable symptom, notwithstanding the prevalence of an epidemic of puerperal fever in the Hospital at the time of her confinement.

In his clinical remarks upon the case, Dr. Barker contended that he had demonstrated beyond cavil—1. That a mal-position of the fœtus in utero can be detected by external manipulation during labor. Auscultation furnished but slight assistance, and the results of an internal examination were entirely negative. The important fact, however, worthy of special notice is, that the position of the fœtus could only be determined when the uterus was in a quiescent state. It follows, therefore, if the most favorable time for detecting the position of the fœtus is in the interval between contractions, that a mal-position can be made out by external manipulation prior to labor; and if the position can be discovered in the interval of the pains of labor, it can also be done one, or two, or even many days before labor. 2. This case demonstrates the possibility of performing version by external manipulation during labor, and, as version by the hand introduced into the uterus was attempted in the absence of pain, he thought this case equally proved that version by external manipulation is possible before labor. But to have the fœtus remain in its

new position it would be necessary to rupture the membranes and induce labor, in order to secure the engagement of the head in the pelvic cavity.

### NURSERY AND CHILD'S HOSPITAL.

#### TWO CASES OF PLEURO-PNEUMONIA WITH PULMONARY ABSCESES WITHOUT CORRESPONDING SYMPTOMS.

[Under the care of GEO. A. PETERS, M.D.]

**Case 1. J. M.**— was admitted May 19th, 1859, at the age of two months. He was very delicate at the time of admission, and had slight bronchitis; in the hands of a wet-nurse he began to improve, and continued to do so till the middle of July, when several attacks of diarrhoea occurred at intervals of three or four days; each lasting not more than twenty-four to thirty-six hours; from the occurrence of these he began to decline, boils made their appearance upon the back part of his head and neck, and there was considerable constitutional disturbance; he was treated with tonics, vegetable and ferruginous, but they were of no sensible benefit, either as regards the eruption or the general condition of the child.

Aug. 1st. Continues to fail, with no apparent cause, except the furuncular eruption and the attacks of diarrhoea.

Aug. 5th. Died suddenly to-day of asphyxia, although he had had no symptom to direct attention to the chest.

**Autopsy—eight hours after death.**—Great emaciation; rigor-mortis; on opening the chest, the right lung was found collapsed, occupying a very small space; it could not be inflated, except in a few places in the lower lobe, which appeared to be pneumonic, having the solid feel belonging to this disease; from one to two ounces of turbid serum, were found in the pleural cavity; both the parietal and pulmonary pleurae were pretty well covered with a fibrinous deposit of a creamy appearance. Some of this had settled in the depending portion of the cavity. On the left side the lung also occupied a very small space, almost entirely collapsed; the upper lobe could be readily inflated, when it had the cushiony feel of the healthy lung; the lower lobe had a healthy appearance, and could be inflated, except a portion in the posterior aspect; measuring perhaps, an inch in diameter; this portion was partially coated with lymph, and was found to contain two small abscesses, one closed, the other opening externally on the surface of the lung, and internally into the bronchial tube. As the air passed directly through this opening, it was impossible to ascertain whether this part of the lobe could be inflated; the closed abscess contained from one-third to half a dram of disintegrated lung tissue and pus-corpuscles as shown by the microscope; foramen ovale open; weight of liver,  $\frac{3}{4}$  vjss. Stomach and jejunum healthy; the mucous membrane lining the lower part of the ileum and the whole extent of the colon was vascular, and that of the latter considerably thickened, but no ulceration was noticed; mesenteric glands enlarged and of a lighter color than in the healthy state.

**Case 2. M. J.**— was admitted into the hospital, Oct. 7th, 1859, at the age of about four months. At the time of admission she was delicate and suffering from diarrhoea, which was relieved by castor oil mixture. After this she continued to improve until the latter part of October, when her abdomen became distended and tympanitic, and she appeared to suffer much pain. This condition was relieved by aromatic drinks and warm applications, but it continued to return at intervals. Pains were taken to nourish and sustain her, and hopes were entertained of her ultimate recovery.

On the second of November, however, at 10 P. M., she was suddenly seized with violent dyspnoea, which terminated fatally in about a quarter of an hour. Previously to the dyspnoea no cough had been noticed, or other symptom referable to the chest.

**Autopsy—thirty-eight hours after death.**—Body considerably emaciated; slight rigor mortis; on opening the thorax, the left lung was found healthy with the exception of slight hypostatic congestion; the right lung was adherent to the diaphragm, and to a considerable part of the costal pleura by fibrinous exudation; the whole lung appeared somewhat compressed and was non-crepitant; the upper lobe floated in water; the middle and lower sank and could not be inflated or but slightly; this portion of the lung contained a few small abscesses filled with purulent matter, each holding scarcely more than a drop; one or two of these appeared to have opened into the pleural cavity, as the air passed through them in attempting to inflate, but possibly they may have been opened in separating the adhesions; in one of the closed abscesses both pus and exudation corpuscles were found with the microscope; the lung surrounding the abscess contained both kinds of epithelial cells, pus, and exudation corpuscles; two or three ounces of fluid were found in the pleural cavity, consisting mainly of fibrinous flocculi, pavement epithelial cells from the pleura, pus, and exudation corpuscles; the lower portion of this fluid, on standing, contained so much pus as to become gelatinous on the addition of acetic acid; heart normal; liver congested and weighing  $\frac{3}{4}$  ix.; mesenteric glands enlarged; kidneys, stomach and small intestines apparently healthy, but the latter distended with gas; the colon showed considerable vascularity in its descending portion, and near the ileo-caecal valves, but no ulceration was observed.

### BROOKLYN CITY HOSPITAL.

#### CASES ILLUSTRATING A NEW AND SUCCESSFUL TREATMENT OF VARICOSE VEINS BY THE INJECTION OF PERSULPHATE OF IRON.

[By JAMES M. MINOR, M.D., Attending Surgeon.]

The following cases possess the double interest of novelty and practical utility.

There are none of a similar character on record, except those in which this treatment was adopted subsequently to, and in imitation of, them.

It will be observed that I have introduced a case of *aneurism*, treated with injections of the perchloride of iron, among cases of *varicose veins*, treated with the *persulphate*.

In doing so I have violated the harmony of pathological relation, in order to illustrate the efficiency and innocuousness of the preparations of iron. The first case was in private practice, the others were treated in Hospital.

**CASE 1.—*Dupuytren's Aneurism cured by the Injection of the Perchloride of Iron.***—On the 9th of November, 1857, I was requested by Dr. Jas. Crane to see Mrs. T. I found a small, pulsating, superficial, aneurismal sac, between the right labium and thigh, about the diameter of a Madeira nut, and projecting about half an inch above the surface. From it projected a small nipple-like or rather tubular off-shoot, from which, previous to its ligation by Dr. Crane, arterial blood spouted *per saltum*. Mrs. T.'s account of it was, that about seventeen years previously she had received a severe blow at that point while entering a stage-coach, from the heavy iron hook attached to one end of the "back strap" of the middle seat, causing very severe pain at the time, but of short duration. Is not absolutely sure how long she has felt pulsation, but thinks that about a year since it became very distinct, and assumed the purplish tinge it now has; pulsation was more active at every menstrual period. A careful examination, by alternate pressure upon the femoral, and at a point posterior to the sac, shows a supply trunk, probably from some one of the perforating branches of the profunda femoris in front, and the obturator behind.

Upon consultation between Drs. Crane, Isaacs, and myself, and at Dr. Isaacs' suggestion it was determined to use injections of powerful styptics. This course was adopted in

Perineal



view of the manifold difficulties in the way of an effort to tie the supply trunks.

There were four several attempts made, at intervals of about a week, with solutions of lactate, muriated tincture, and perchloride of iron, using at the same time Signoroni's tourniquet to control the circulation through the femoral artery, and lessen the tendency to wash away the newly-formed clot. It was impossible to exert much force in controlling the current from the obturator artery, as the finger alone could be used.

The solution of the perchloride alone sufficed, with the aid of the tourniquet, and the recumbent posture, to effectually coagulate the blood and block up the sac. The pain caused by the perchloride was very severe, and continued for more than twelve hours, and was followed by considerable inflammatory action. It was completely successful, and Mrs. T. recovered with entire obliteration of the sac. The tourniquet was kept on for some days, being loosened at intervals, to lessen the intolerable pain caused by the pressure. The filling by granulation of the cavity left where the coagulum came away (which it did by ulceration) occupied some weeks.

The notes of this case having been lost, will account for the omission of some points of interest. They have been drawn out from memory, and by the aid of the patient.

The following cases of varicose veins, treated by the injection of persulphate of iron, occurred in the Brooklyn City Hospital, the notes of which are furnished me by R. P. Moore, M.D., House-Surgeon:

CASE 2.—*Varicose Veins of Leg—Injection of Persulphate of Iron—Cured.*—John Towle, admitted March 1st, 1859 (Dr. Enos on duty), with ulcer from varicose vein on leg, of five years' duration; it has healed repeatedly, but again re-opened. Ordered poultice, and rest in recumbent posture. April 25th.—Ulcers nearly healed. Injected liquor ferri persulphat. gtt. x.\* May 2d.—Veins obliterated at point of injection; neighboring branches still varicose. May 20th.—Ulcers entirely healed, and patient permitted to go out on a pass. Returned drunk, with abrasion of newly cicatrized surface. June 13th.—Discharged cured.

CASE 3.—*Varicose Veins of Scrotum—Injection of Persulphate of Iron—Cured.*—J. T., æt. 22, American, admitted under Dr. Minor Oct. 24th, 1859, with varicose condition of scrotal veins of left side. Has enjoyed very good general health. For six months past has suffered much pain from distended veins of scrotum, extending through spermatic cord to inguinal canal of that side, and also in the testicle; can obtain no relief except in recumbent posture. Ordered cathartic. Suffers with languor and debility from involuntary seminal emissions, after which the pain is much aggravated. Oct. 28th.—Injected four drops of a solution of persulphate of iron (four parts of water to one of persulphate), with Pravatz's syringe, as modified by Tiemann. Patient was made to stand erect, in order to fill the veins, and make them more distinct and prominent—a necessary precaution in such loose tissues as are found in that region. He fainted, but was soon restored by placing him in a recumbent posture. The operation scarcely caused any pain, either at the time or subsequently. A firm coagulum was formed in thirty seconds. Ordered cloths dipped in water to the part, and recumbent posture. Nov. 3d.—The clot formed by persulph. ferri gives indications of coming away by ulceration. Has felt less pain in cord since operation; nor does he feel any pain at the point of puncture. Feb. 6th.—Clot came away last night, leaving a healthy granulating surface. 26th.—Discharged cured.

CASE 4.—*Varicose Veins of Scrotum—Second Injection—Cured.*—James Taylor was admitted a short time after his discharge in November last, with varicose condition of other deep scrotal veins near the cord. The vermiform mass of enlarged veins around the point of former operation are entirely obliterated. Has been variously treated since second admission, but without resort to operative measures.

Feb. 14th.—Veins increasing in size, attended with pain. Injected three drops of a solution of persulphate of iron in the proportion of one part persulphate to two of distilled water, followed by immediate coagulation of blood, as on former occasion, and with as little pain. 15th.—Injection seems to have entirely relieved the pain in the cord, and he expresses himself as feeling better in every particular. 19th.—Continues comfortable. Some pain and heat at point of puncture, where there is an exceedingly hard and prominent tumor. Tumor is close to the cord, and seems in some measure to involve it. Seminal emissions occur at long intervals now. Cold water dressings. 26th.—Clot decreasing in size, but still very hard. No appearance of ulcerating, as on former use of the persulphate. March 1st.—Tumor has steadily decreased in size; but little hardness remains. Veins completely obliterated when injected, as well as all others which were enlarged.

CASE 5.—*Varicose Veins of Leg—Injection of Persulphate of Iron—Cured.*—Carl de Buque, admitted Dec. 22d, 1859, with paronychia of left thumb. Varicose veins in left leg, which he has had for many years. Veins very much distended at one point. Owing to the size of the veins it was thought necessary to insert a larger quantity of the solution than usual. Feb. 11th.—Ten drops of a solution of the strength of one part persulphate to three of water was used. 12th.—A clot has formed, and obstructed the vein; though it does not appear to be so firm as in previous cases. 14th.—Complains of pain at point of puncture, where there is a considerable swelling and redness. Apply cold lotion. 16th.—Inflammation and pain subsiding. Continue lotion. No constitutional disturbance at any time. 22d.—Tumor lessening in size, and redness disappearing. March 10th.—All inflammatory symptoms have subsided, and the vein is obliterated at point of operation.

CASE 6.—*Varicose Veins of Leg—Injection of Persulphate of Iron—Cured.*—James Flemming was admitted December 29th, 1859, with secondary syphilis, and ulcers on right leg: has varicose veins of the same leg, which are increasing in size, and he expresses a wish to be operated on for their relief. Feb. 11th.—Injected as usual, three drops of a solution of the persulphate of iron, one part to four of water. A second puncture was made below the first. 13th.—Coagulum formed, but not so marked as in other cases. No inflammation about punctures. 19th.—Ulcer on leg has improved rapidly since operation. 25th.—Vein obliterated between points of operation. 27th.—Old ulcer cicatrized, and he desires to leave the hospital. —Discharged cured.

It may be desirable to state briefly, the mode of procedure in the injection of varicose veins. A Pravatz's syringe as modified by Mr. Tiemann is the instrument used. This is a very small syringe of vulcanized rubber having a small (almost capillary) canula screwed to its lower end. This canula is cut obliquely at its extremity somewhat after the manner of a pen, ending in a sharp point. The piston rod is graduated to drops, to admit of the use of any quantity however small.

The canula being screwed on, the quantity of the solution desired to be used is drawn in through the canula, which is then plunged into the vein, the patient standing erect. The finger of an assistant is then placed upon the vein, a little above and below the point of puncture, and firm pressure made; the piston is then forced down and the fluid injected. It is important that the pressure on the cardiac side of the puncture, should be sufficient to completely stop the upward current, as otherwise portions of the clot might be carried into the circulation. The pressure need be kept up for a minute or two only.

This completes the operation. The patient is placed in the recumbent posture, and cold water dressings applied, with directions not to rise for some days. The above mode of treatment of varicose veins, would seem to promise a safe, prompt, and painless cure of a most uncomfortable, painful, and sometimes perilous complaint, for which, heretofore, there have been only uncertain and dangerous expedients.

\* Official solution contains 43 per cent. of the solid persulphate.

The persulphate of iron, as far as heretofore used, seems to excite adhesive inflammation alone, thus avoiding that formidable affection pyæmia; and I feel confident in recommending it to the profession, as a safe, simple, and almost certain remedy for varicose veins, and with some qualifications, for *small* aneurisms.

### ST. LUKE'S HOSPITAL.

#### TWO CASES OF MORBUS COXARIUS SUCCESSFULLY TREATED BY AN APPARATUS MAKING EXTENSION AND COUNTER-EXTENSION.

[Reported by EDWARD B. DALTON, M.D., Resident Physician.]

Two boys, one 4, the other 5 years of age, entered the hospital, the one on the 12th of January, and the other on the 2d of February last, both suffering from morbus coxarius.

The symptoms exhibited in these two cases were so nearly identical, and the treatment and progress thus far has been so uniform that they may readily be described together. The only striking difference in the symptoms was, that in the case of the youngest the general health was much more seriously impaired than in the other. In one the right hip, and in the other the left, was the seat of disease. In neither case had there ever been any abscess, or ulcer over the joint. In each there was tenderness, heat, and swelling in that situation, and intense pain was caused by the slightest movement of the limb. Under the direction of Dr. George A. Peters, the attending surgeon, the patients were put upon the use of constitutional tonics, and a few days subsequent to their admission, Dr. Henry G. Davis, of this city, applied his apparatus for the cure of this disease. The treatment by this apparatus consists in first extending the limb for several weeks, more or less, until its length equals that of its fellow, or as nearly so as practicable, and then retaining the limb in position by means of a splint, which, while it keeps up extension, allows the patient to enjoy the advantages of exercise and fresh air. To accomplish the first end, a broad strip of adhesive plaster is applied both to the outer and the inner aspect of the affected limb throughout its entire length, and over these again a third strip is carried spirally round the limb from the hip to the ankle. A bandage is then applied from the toes up, leaving exposed and free the lower extremities of the side straps, to which are attached bands of webbing made to buckle in a loop beneath the foot. To this loop is attached a cord traversing a pulley at the foot of the bed, and sustaining a weight. In each of these cases a weight of three pounds was first used, increased after a week to four pounds. A few days after the application of this apparatus, the relief experienced by the patients was very apparent. The pain in the joint, as well as that produced by motion, began at once to diminish. This was strikingly evident from the fact that the patients' sleep, which had before been incessantly broken by their own involuntary movements, became much more quiet. Their general health, too, rapidly improved. This amendment became daily more marked, until after some four or five weeks all suffering had ceased. The general health of both patients was excellent, and a very considerable motion of the affected joints caused no complaint. Within a few weeks subsequent to the commencement of this treatment, the splint was frequently substituted temporarily for the cord and weight. This splint consists of a narrow bar or band of steel, adapted to the form of the outside of the thigh and leg, and having a hinge-joint near its middle, capable of being made immovable. The counter-extension is accomplished by means of a perineal band of India-rubber, fastened at either end to a cord of cat-gut which traverses a small ring at the upper extremity of the splint. The splint itself terminates just above the external malleolus, where it is kept in place by the band of webbing attached to the outer adhesive strap, which is carried up over the end of

the splint and fastened by a buckle attached to the shaft of the latter some four inches above.

The splint is applied with its upper and lower portions forming an angle at the hinge, and extension is produced by obliterating this angle, and thus bringing the splint throughout its entire length into contact with the bandaged limb. The movements of the hip-joint are not interfered with. The application of the splint is the work of only a few moments, and gives rise to no pain or inconvenience. In these two cases it has now been worn daily for several weeks, and only removed at bed-time, to be immediately replaced by the weight. In both instances the limbs are kept constantly at their natural length, and can be moved with great freedom without causing any pain. The tenderness, heat, and swelling over the joints have long since subsided, and the patients are both in the enjoyment of fine health. The light and compact character of the splint enables them to be dressed, and to have their regular exercise, and to be out-of-doors whenever advisable.

### LONG ISLAND COLLEGE HOSPITAL.

#### CASES OF PARALYSIS CONNECTED WITH DENTITION; WITH REMARKS BY PROF. F. H. HAMILTON.

[Reported by JOHN G. JOHNSON, M.D.]

There have been recently presented to the class six cases of paralysis connected with dentition.

*Case 1.*—A little girl nineteen months of age, in whose case the left arm is paralysed. There is wasting of the deltoid and of the muscles of the arm and forearm—with complete loss of power. The paralysis is of three months standing.

*Case 2.*—A girl of three years of age—paralysis of the left leg. The heel is raised considerably from the ground. The muscles of the leg are more wasted than those of the thigh. In attempting to walk, she drags the foot sideways.

*Case 3.*—Mary Gorham, two years and one month old. Eight months ago she had a fever, after this the mother noticed that the child could not use the left leg. There is a tendency of the foot to rotate outward, she drags the toe. Paralysis is mostly from the knee downwards. There is wasting of the limb. In this case it is to be attributed to the fever. Prof. Hamilton has never seen a case in which infantile paralysis could be attributed to the abuse or use of calomel.

*Case 4.*—Boy three years and a half old, in all respects healthy, except loss of power of left leg. No traceable cause, unless diarrhoea attending teething. The limb is wasted and heel is elevated, there is dragging of the toe—sensation in the limb is perfect.

*Cases 5 and 6.*—Were both boys, and the paralysis confined to the right leg—presenting the same symptoms of wasting of the limb, loss of power, elevated heel, &c.; no assignable cause for the paralysis.

*Remarks.*—Infantile paralysis occurs generally at some time during the period of first teething, and seems to have a more or less direct connection with this process. There are several periods in life, in which the system or portions of the system undergo remarkable changes, and great nervous derangements are apt to ensue. The period of the first dentition, is one of these, and among the consequences of the nervous disturbances occasioned by the development of the teeth are convulsions, hydrocephalus, diarrhoea, and *paralysis*. The other periods to which I allude, are puberty in both male and female, and "the change of life," or the period of cessation of the menses in the female. I think that I have observed, also, that at the period of "change of life" in the male, paralysis and cerebral apoplexy are exceedingly liable to occur.

Infantile paralysis is more common in the legs than in the arms; yet we see it occasionally in the arms. It generally

exists but in one leg, occurring in most cases suddenly, and not unfrequently after a diarrhoea or fever of some form, or after exposure to the cold. Its frequent sequence to some temporary illness has often led parents to suppose that it was due to the medicine which had been given, especially to mercury; but I have never been able to trace it to the use of mercury, in any form. I have never seen the paralysis complete; it being, in the case of the lower extremities, confined mostly to that portion of the limb which is below the knee, and existing much more in the nerves of motion than in those of sensation.

The child can generally stand upon, and even walk with the limb tolerably well; but the foot turns out whenever the weight of the body rests upon it, and the gait is unsteady and insecure. He is especially unable, when sitting, to raise and extend the leg upon the thigh, but he can generally flex the thigh upon the body without difficulty. After a time the muscles become sensibly diminished in size, especially the muscles of the leg; and if the paralysis continues, the leg does not increase in length quite as rapidly as the other, and the foot becomes more and more turned out at the ankle.

**Treatment.**—First of all, if the case is seen soon after the occurrence, the bowels should be well evacuated, and the condition of the gums should be looked to. The child should then be turned out of doors, and be permitted to gather health and strength by exercise in the open air. By use, mainly, are these muscles to be again restored to action. The little patient should therefore be encouraged to walk, and if old enough he must be directed to sit occasionally upon a chair and swing his leg back and forward in flexion and extension. No apparatus ought to be employed to support the ankle or the knee, unless these joints are becoming greatly deflected, or the limb is totally unable to support its weight. When apparatus is substituted for the muscles, the muscles being thrown into disuse, are not in a condition to gain strength. Upon this point there is a popular error which needs to be corrected. When a young man begins to stoop, or his spine begins to fall to one side or the other, his friends tell him he must get a shoulder-brace or a spine-supporter—and there are always plenty of them hanging in the windows of drug-shops, patented and recommended for this very purpose. Now the probability is, that this fall of the shoulders or curvature of the spine, is entirely due to muscular weakness. The great trapezoid does not pull the scapula well back, and if we pull them back with a shoulder-brace, leaving the muscles nothing to do, they will rapidly become atrophied, and when the brace is taken off the shoulders, will fall forward more than ever. It would be much better to put the brace in front, and tie the shoulders forward, and then by the constant antagonism the trapezoid would be strengthened. Those persons who carry weights upon their heads, grow straight; the spine being made to erect itself by the action of the muscles, whose power is thus developed and perfected. It is this use of the muscles in carrying the gun, which makes the soldier and the hunter so erect. The same principle applies to these cases of infantile paralysis. The limb should be kept in constant use, and no apparatus should be employed to support the limb, except in the few extreme cases mentioned. It is well, also, to bathe the limbs in cold water once a day, and to rub them freely afterwards. Galvanism and electricity also deserve a trial.

Usually the recovery is very slow, extending through a period of several years; but I have been enabled to follow the history of enough of these cases to warrant me in assuring the parents that they will almost certainly improve, and that there is a reasonable probability of a final and complete recovery.

**CHANGE OF STATION.**—Assistant Surgeon John F. Hammond has been ordered to relieve Assistant Surgeon John Campbell at West Point.

#### TERMS OF THE AMERICAN MEDICAL TIMES.

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\*.\* The publishers respectfully intimate, in order to save trouble, that a remittance must accompany an order for the Journal.

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## American Medical Times.

SATURDAY, JULY 7, 1860.

THE AMERICAN MEDICAL TIMES, the first number of which we now present to the profession, will give to most of our readers the first intimation which they have received, that important changes have taken place in the NEW YORK JOURNAL OF MEDICINE. As no preliminary announcement has been made, some may be led to believe that these improvements have not been long contemplated, and have therefore been completed without due reflection and preparation. We deem it but an act of justice to them, and equally so to ourselves, to state briefly the reasons which have led to these changes.

With the issue of the last number, THE NEW YORK JOURNAL OF MEDICINE completed the seventeenth year of its publication, having been established in July, 1843. It was originally projected by SAMUEL FORRY, M.D., who during his brief career in this city won, by his profoundly scientific essays, an enviable fame, and by his gentleness and urbanity, an abiding place in the hearts of his professional brethren. In his prospectus Dr. FORRY says:—"The leading objects sought in the establishment of this Journal are, to elevate the character and dignity of the American Medical Profession generally, and especially to afford a medium, free from all individual interests and party, through which the rich results of the experience of the profession in this city, much of which is now lost, may be communicated." That these praiseworthy objects have been wholly realized, the history of that periodical fully attests. Under the judicious editorial management of PROF. CHARLES A. LEE, and S. S. PURPLE, M.D., it acquired during the first ten years of its publication, the entire confidence of the profession, and a circulation second to no other similar periodical in this country. Since that period it has pursued the even tenor of its way, maintaining its position as a high-toned scientific journal, and never deviating from the strictest rules of professional decorum and courtesy. In no instance have its pages been sullied with the personal reflections or improper insinuations and allusions which are liable to enter the discussions of authors who are advocating favorite theories. As a medium for the communication of scientific intelligence, it has always been a free, independent journal, subject to no individual or party interests of any kind whatever. And that it has proved an acceptable organ of the profes-



sion, the thirty-four volumes now completed, filled with elaborately written monographs and papers abundantly prove.

But well as that periodical has served its day and generation, and eminently as it has realized the great idea of its founder, the important question has recently occurred to the minds of many of its friends; is it to-day subserving in the highest degree the best interests of the profession? During the period of its existence, what marvellous changes have taken place in the social condition of our people! How rapid has been their advancement in population, in the aggrandizement of wealth and power, and in all the arts of a higher civilization! Within the last seventeen years, a complete revolution has occurred in nearly every department of industry. Science has demonstrated and art developed in multifarious methods, the truest aids to human progress. Every department of industrial enterprise has been metamorphosed by the applied sciences. The means and methods, the instruments and appliances of that period, are now discarded or treated with ridicule and contempt. But it is not to any occult causes, that we are to attribute this remarkable stimulus of the human intellect, which has so marvellously revolutionized society; the application of steam to travel, and electricity to the communication of intelligence, have been the most efficient agencies in effecting this result. They have so compacted society however widely scattered, and centralized commerce, science, and letters, that the people of every part of our widely extended republic, with all their diversity of interests, are brought in their thoughts and sympathies within the circle of a single community. With these improvements in man's social condition, commerce and every branch of industry keep pace and shrewdly seize the golden opportunities as they occur, to enlarge the domain of their operations. With these increased facilities for inter-communication comes a demand upon the press for the more frequent and rapid diffusion of intelligence; monthlies have changed to weeklies, weeklies to dailies, and dailies must have almost hourly editions.

Scientific medicine now partakes largely of that spirit of inquiry and restless activity which characterizes the age. In every department ardent and impulsive adventurers, with all the aids of modern invention, are enlarging the bounds of knowledge, and daily unfolding truths and principles of the greatest practical utility. These developments in the medical sciences are not now made at long intervals, but they are daily and almost hourly occurrences. He who maintains a familiar acquaintance with latest improvements, even in a single department of medicine, must in our times be a student of unremitting application. And not only is there an active spirit of inquiry and research in enlarging and more thoroughly exploring the domain of medical science; but our hospitals, the great repositories of accurate observation, and our schools, where these facts are reduced to systems and made available, are heartily co-operating in the great work of medical education, and the diffusion of practical knowledge. This rapid development of every branch of medicine, and the increasing desire on the part of the profession at large, for the earlier and more frequent dissemination of scientific intelligence, imperatively demands the co-operation of the metropolitan medical press.

These are some of the considerations which have led to the conclusion that this journal, by a change of form and more frequent issue, might be made far more conducive

to the interests of the profession, both of the city and country, than it is at present. However well it may have been adapted to the period of its first publication, it cannot to-day in its present form faithfully represent New York, with her population increased three-fold, her numerous and well appointed hospitals, her flourishing schools of medicine, and her gradual centralization of medical interests. With a full knowledge of our increased responsibilities and labors, we have, with the sole object of rendering this Journal in the highest degree useful to the profession, determined to exchange bi-monthly for weekly medical journalism. We are aware that other laborers have preceded us in this field, fruitful at least in harassing cares and constant toil, and we desire to be co-workers with them in the development of its resources.

In entering upon the duties of weekly medical journalism a word of explanation in regard to its spirit and mission, and the special duties and obligations which we feel are imposed upon us, is due to the professional public.

It is designed that the pages of this journal shall furnish a faithful and timely record of scientific progress and practical improvements in the healing art. In every department of medical science and professional literature, in the several branches of special pathology, practice, surgery, hygiene, and medical polity, distinguished contributors have already been secured, and we cordially invite the co-operation of others in all sections of our country. Original observations and researches, scientific and practical reports, condensed *résumés*, properly reported cases, and individual facts, will be gratefully received, and properly acknowledged. It is desired that these pages shall furnish an acceptable and popular medium for the individual and united utterances of medical men on all subjects connected with the progress and interests of medical science, the most advanced views in sound medical philosophy, and the defence or the criticism of both the old and the new, as well as the proper discussion of questions relating to the common interests, obligations, and wants of our sacred profession.

In connection with the department of Hygiene and State Medicine, it is designed to discuss practical questions and record the evidences of scientific progress in those important applications of our art, and we hope, also, to keep up an Epidemiological Record, that shall embrace a reliable history of epidemic and endemic maladies throughout our country and the world. In order to accomplish this important purpose, we cordially invite the attention and correspondence of all competent observers of epidemic or of epizootic diseases.

The very liberal arrangements which have been made by the publishers, for securing full reports from all the hospitals, and the various medical institutions and associations in the cities of New York and Brooklyn, cannot fail to give the highest practical value to the journal, and will tend strongly to promote the interests and multiply the good works of those several sources of medical intelligence, for

"A chief's among you taking notes,  
And, faith, he'll print it!"

While this Journal designs to present to the profession an accurate, full, and impartial record of medical progress and practice, as set forth in the foregoing remarks, it proposes also to undertake another and more difficult work. It is the determination of its projectors, and the wish of its pub-

lishers, that its editorial columns should faithfully and fearlessly express the highest sentiments, the noblest aspirations, the common desires, the just criticisms, and the friendly warnings of all those who by precept and example strive to honor and fulfil the sacred vocation of the physician.

Truthfully to mirror forth, and, at proper times, to lead the sentiments and the progressive activities of the medical profession—from week to week vigilantly striving to daguerreotype the features and interpret the real significance of passing events—yet,

\* \* \* "Nothing extenuate,  
Nor set down aught in malice,"

will be the constant and conscientious endeavor of this Journal. By every suitable means shall its pages encourage and promote the intimate and fraternal association and communion of medical men, ever striving to elevate the standard and ennoble the quality of medical education and professional ethics. To this end we desire that its columns should faithfully and acceptably utter for the whole profession—the noblest sentiments and the most advanced opinions of those who best have loved and honored its high vocation.

The sacred unity, the high obligations, and the mutual interests and common rights of medical men will be recognized and encouraged on every page and in every paragraph, and under no circumstances will partizan and polemical discord be permitted to supplant the harmonies of professional charity and good-will. Fearlessly it will defend and promulgate the claims, the dignity, and the legitimate undertakings of the medical profession; and not less boldly will it endeavor to expose and root out those pestilent evils that disturb the peace, and threaten the security and usefulness of professional associations and medical institutions, and which seriously depress the popular status and moral influence of the profession at large.

In fulfilment of its mission as the faithful defender of the sacred trusts and the fraternal interests of medical life, this Journal will endeavor, by precept and example, to inculcate a conscientious regard for all the ethical proprieties and relative duties of the profession; and, in view of the obligations of humanity, and the sanctions of divine law, we shall, by every consideration and event, strive to illustrate and increase the professional and the popular estimate of that boon—*human life*—which in hospitals, asylums, almshouses, or penitentiaries, as well as in the homes of the people, is still the most sacred and precious of gifts divine.

In this spirit, and regarding physicians as the appointed ministers and conservators of life and the public health, no efforts will be spared, on our part, to keep posted in all that relates to the management and experience of the public institutions in our midst. Especially will Hygiene and every question relating to human health or public salubrity receive our most vigilant and faithful attention; while the enormities of empiricism, and every form of charlatany, whether within or without the pale of the profession, will invite continual exposure and unsparing criticism.

With earnest endeavor and coöperation to secure for the profession a clear and universal recognition of its true status and mission, and believing that in our national Republic the medical profession is called upon to erect its own standards, and define its own rights, and the laws which shall govern its members, we shall steadily labor to advance the great primary objects of the AMERICAN MEDICAL ASSOCIATION, as the grand Congress of letters, polity, and ethical law,

for the Republic of American Medicine; and with equal earnestness shall we endeavor to inculcate the reciprocal obligations and claims of the profession.

## THE AMERICAN MEDICAL ASSOCIATION.

### ITS RECENT MEETING AT NEW HAVEN.

THE existence of a NATIONAL MEDICAL CONGRESS in the United States is so fully in accordance with the history and spirit of our Republican institutions that its practical workings and ultimate destiny have already become, in the medical world, subject to comments, criticism, and prophecy, that may justly admonish us to avoid the evils to which our voluntary associations and the democratic principles and usages of our times and country are peculiarly liable.

Called into existence by the urgent necessities of the profession, for the preservation of its honor, the promotion of its usefulness, and the elevation of its educational and its ethical standards, the American Medical Association has for thirteen years been steadily laboring to advance these grand designs, and with a success that is indicated not only by its twelve ponderous volumes of proceedings and reports, but by the universal interest in the discussions, and respect for the measures of the Association from year to year. Its first great work—that which laid the foundations for a higher state of professional unity and good will—commanded the highest respect from all the local associations of physicians in the several States of our Republic, so that the National Association had scarcely reached the third year of its existence before the code of medical ethics which it had submitted to the profession in 1847, was almost universally adopted by State and district medical societies throughout the land, carrying its spirit of true honor, dignity, charity, and moral purity into all the intercourse and duties of medical life.

Each returning year has been marked by progress and improvements of great importance, as the accredited representatives of the profession have gathered in the councils of the Association, and probably none of its annual sessions have been more deeply interesting in this respect than that at New Haven.

As will be noticed in the summary of its proceedings, an unusual number of interesting reports was presented by various committees. Among the most valuable contributions of a scientific character that came under our personal observation at the meeting this year, was an elaborate monograph on the Epidemics of the State of New York, by Dr. JOSEPH M. SMITH, of this city; another on the Medical Topography and Epidemics of North Carolina, by Dr. J. H. DICKSON, of Wilmington; and one by Dr. L. A. SAYRE of this city, on the Pathology of Articular Inflammation. These and all other contributions to medical literature, were severally referred to the appropriate sections, as contemplated by the resolution of Dr. J. B. LINDSLEY, and the action of the Association last year,—a provision, by the way, which promises to become of vast practical importance, and which added greatly to the interest of the meeting at New Haven.

It was reserved for the Committee on Medical Education to present the theme of most deeply absorbing interest to the convention, in a thorough, extended, well-drawn, and somewhat radical report, advocating most important and sweeping reforms. The resolutions submitted by the

Committee faithfully embody the spirit and recommendations of the report. Several of the resolutions were adopted by the Association, but the earnest and widely divergent expressions of opinion to which the discussions gave rise, served to demonstrate the fact that the universally admitted defects and evils in the present system of medical education in our country cannot be reformed by any local and spasmodic efforts, but that any reliable, hearty, and wide-spread improvement must depend primarily upon the moral sense and an ennobled *esprit du corps* in the profession at large. But we must forbear further remarks on this subject until we have the report on Education in our hands. Though neither the National Association of Physicians nor the Convention of Medical Teachers have yet been able to settle upon an acceptable plan of reform,—and much less, to agree in their own counsels on the subject, both bodies may safely report progress; and as they but reflect the popular sentiment of the profession, we may rest assured that when the great heart and body of the medical public are right the acts and decisions of the Congress of its chosen representatives will accord with the advanced views and earnest wishes of the noble men who now strive by word and deed to elevate the standard of medical life and professional learning.

## Reports of Societies.

### AMERICAN MEDICAL ASSOCIATION.

#### THIRTEENTH ANNUAL MEETING.

The thirteenth annual meeting of the American Medical Association, was held in the city of New Haven, June 5th, and remained in session the two following days.

#### MORNING SESSION.

TUESDAY, June 5th.

The Association was called to order at 11 A.M., by the President, HENRY MILLER, M.D., of Kentucky. An appropriate prayer was made by Prof. FISHER, of Yale College, after which Dr. JONATHAN KNIGHT, on behalf of the Committee of Reception, tendered to all a hearty welcome. Dr. CHAS. HOOKER, as chairman of the Committee of Arrangements, followed in an appropriate address, assuring the Association that the honor done to New Haven was sincerely appreciated, and that not only the medical fraternity, but the citizens generally, were determined that the meeting should be a season of pleasant social intercourse, as well as profit to all the members.

The roll was next called by the Secretary, Dr. BEMISS, of Kentucky.

On motion of Dr. ATLEE, all the medical officers of the Army or Navy that were present, were invited to take part in the deliberations of the body.

The Committee on Parliamentary Rules made a statement to the effect that the report, principally the work of the chairman, Dr. CHAS. A. LINDSLEY, of Conn., was ready, and suggested the propriety of having copies of the same printed for distribution among the members, before they were regularly acted upon. After discussion the report was laid on the table.

A recess was here taken, to form the Committee on Nominations, consisting of one representative from each State.

About one o'clock, the association was called to order, when the names of the gentlemen composing the said Committee were reported as follows:—

District of Columbia, Dr. Boyle; Maryland, C. C. Cox; Kentucky, R. I. Breckenridge; North Carolina, James H. Dixon; Tennessee, I. S. White; Delaware, Lewis P. Bush; Louisiana, Austin Flint, Jr.; Minnesota, D. W. Hand; Georgia, N. W. Brown; Massachusetts, D. Humphreys Storer; Maine, Amos Nourse; Indiana, Daniel Meeker; New Jersey, J. B. English; Rhode Island, James H. Eldridge; New Hampshire, Geo. H.

Hubbard; Illinois, A. S. McArthur; Mississippi, U. G. Williams; Michigan, C. L. Ford; Pennsylvania, Wilson Jewell; Iowa, D. L. McGugin; Ohio, Robert Thompson; Missouri, M. A. Pallen; Vermont, Charles L. Allen; Virginia, James H. Conning; Connecticut, L. N. Beardsley; South Carolina, H. R. Frost; New York, H. D. Bulkley.

On motion, the Committee of Arrangements were requested to invite the members of the Connecticut Legislature to be present during the delivery of the President's Valedictory Address.

On motion of Dr. C. HOOKER, the Nominating Committee were requested to meet immediately after adjournment in the Trumbull Gallery.

The meeting then adjourned until 3 P.M.

#### AFTERNOON SESSION.

The Association was called to order by the President at 3 o'clock P.M.

Gov. BUCKINGHAM and Lieut. Gov. CATLIN appeared on the stage and were introduced to the Association. Several members of the Legislature were also present.

The President next proceeded to read his retiring address. In the course of his remarks he referred to the subject of criminal abortion, as a practice which was prevalent to an alarming extent among the community, and urged the necessity of legislators adopting such measures as would tend to prevent, if not arrest, the growth of the evil. The system of medical education received from him also a well merited criticism. He maintained that the qualifications of the medical professors were not sufficiently insisted upon in all cases, neither as a general rule were the examinations of students for the degree of Doctor of Medicine, as strict and thorough as they should be. In this connexion he pointed out the importance of preliminary education in students of medicine, as one of the surest steps towards the raising the profession to its proper standard.

Dr. ASKEW, in behalf of the Nominating Committee, next reported the names of the following gentlemen as officers for the ensuing year:—President—Eli Ives, Conn.; Vice Presidents—Wilson Jewell, Pa.; A. P. Palmer, Mich.; Joseph P. Logan, Ga.; J. N. McDowell, Mo. Treasurer—Caspar Wistar, Pa. The report was unanimously accepted.

After the transaction of business of minor importance the officers elect were severally escorted to their seats upon the stage. Dr. IVES, the President, thanked the Association for the high honor conferred upon him in a few well-timed remarks. Dr. WILSON JEWELL, 1st Vice-President, stated that by the request of the President, he would assume the duties of presiding officer, and hoped by the kind co-operation of the members he should be enabled to do so with strict impartiality.

Dr. DAVIS, of Ill., offered the following resolutions:—

*Resolved*, That the general meetings of the Association, after this day, shall be restricted to the morning sessions, and the afternoon sessions, commencing at 3 o'clock, shall be devoted to the hearing of papers and discussions in the several sections.

*Resolved*, That each section shall choose its own officers, and make its own rules of order.

*Resolved*, That all essays, voluntary communications and reports, except those from the officers of the Association, and the committees on medical education, medical literature, and the committee on prize essays, shall be first presented or referred to the appropriate section and receive its recommendation, before they can be referred to the committee on publication.

The first and second resolutions were adopted; the third, however, called forth an extended discussion, and was finally laid upon the table.

The following gentlemen were appointed a Committee on Voluntary Contributions:—Drs. E. D. FORCE, of Ky.; T. W. BLATCHFORD, N. Y.; N. S. DAVIS, of Ill.; R. LA ROCHE, of Penn.; and T. F. ROCHESTER, of N. Y.

Dr. LA ROCHE was excused from serving, and Dr. REUCHBERGER, of Penn., was appointed in his stead.

The Treasurer's Report and the Report of the Committee on Publication were accepted and referred.

The Association, on motion, then adjourned.

#### EVENING SESSION.

WEDNESDAY, June 6th.

The Association was called to order by Dr. WILSON JEWELL, V. P. After the reading of the previous day's



minutes the rules of order were suspended to allow V. P. DR. LOGAN to offer his resignation; which was accepted.

The Committee on Medical Education, through Dr. REESE of N. Y., reported in favor of establishing additional chairs in the several faculties, of extending its sessions from six to nine months, and giving more facilities for instruction at the bedside. They offered the following preamble and resolutions as part of their report:—

**PREAMBLE.**—Whereas, it is the deliberate judgment of the American Medical Association, that the time has fairly come for the introduction of improvements into the present system of medical education, which shall elevate the existing standard of qualification for the Doctorate, and especially for securing and encouraging a higher degree of attainment in the science and of skill in the art of medicine than has been heretofore accessible to students in our country, and

Whereas, this body of American Physicians is regarded by our fraternity everywhere, as the acknowledged head and representative of the medical profession in the United States, and it is therefore looked to for prescribing the terms and qualifications of those who are henceforth to be admitted and recognised into our fellowship as brethren and equals in the profession; therefore,

**Resolved,** That it be hereafter regarded as an indispensable pre-requisite to enrolment as a student of medicine in the office of any regular physician, that the party shall be at least seventeen years of age, of good moral character and habits, and shall have received a good English, classical and mathematical education, and be able to read and translate the Latin language, and have an elementary knowledge of Greek, so far, at least, as to be able to trace the derivations from it to the English language.

**Resolved,** That this same requisite be made indispensable before matriculation in any regular medical college can be allowed, and that the faculty of such College, and the preceptor of such candidate for enrolment, be required to ascertain such qualification by actual examination, and to certify thereto.

**Resolved,** That the term of study in the office of a regular practitioner, including attendance upon lectures, be, and is hereby extended to four years, the last year to be mainly employed in receiving clinical instruction in medicine, surgery, and midwifery.

**Resolved,** That three full courses of lectures in a regularly incorporated college, or other body of lecturers recognised by the Association, be required of all candidates for the degree of Doctor in Medicine. Said candidate may be admitted to examination after three full years of study, on all the branches which they have been required to study, except clinical medicine, as above.

**Resolved,** That the period of instruction in every College be extended through the full term of nine months in each year, and that this time be divided into two sessions, the first to be chiefly occupied in instruction in the elementary branches only, and the latter to the practical and more complete branches. Those in attendance upon the former to constitute the junior class, and that upon the latter the senior. Not more than four lectures to be delivered on each day in either of the departments, and that each lecture be preceded by a recapitulation, in the form of question and answer, of the lectures of the day before.

**Resolved,** That the number of professors in each college should be increased, so as to bear some proportion to the largely increased number of branches, a knowledge of which is necessary. This increase to be made in addition to those holding clinical chairs.

**Resolved,** That the examination of all the students for matriculation, which admits them into the junior class, shall be repeated before their entrance into the senior class, either by the Faculty, or by examiners appointed by them for the purpose, who shall certify in the one case to the fulness of their preliminary education, and in the other to their improvement, under courses of instruction in the junior or elementary department. Admission to the senior class should be contingent upon this latter examination. Similar examinations should be required at the commencement of each session, as to the improvement made in the preceding term.

**Resolved,** That the final examination for graduation, if made by the Faculty, should be in the presence of each other, and should be witnessed and certified by a board or a committee of equal numbers, to be appointed for the purpose by each State Society, within whose bounds any college may be located, or by the Faculty, and without whose approval the degree should not be conferred. Due notice to be given by the Faculty of the time and place for the examination, and each candidate to be separately examined.

**Resolved,** That no medical college be recognised by the American Medical Association to be complete in its organization, and prepared to furnish the requisite instruction, which does not either possess a hospital of its own, or which has not made arrangements with a hospital containing not less than 80 beds, for the students of the college receiving regular clinical instruction, before being licensed to practice.

**Resolved,** That the so-called "College Clinics" cannot, in any useful or practical sense, be looked on as furnishing an adequate substitute for the clinical teaching required.

**Resolved,** That this Association regard with marked disapproval a practice which prevails with some of the Faculties of the Schools, viz: Of examining those students who are candidates for a degree, before the expiration of the regular session, and while the lectures are still in progress.

**Resolved,** That the titles of the several chairs in a school, as announced in its curriculum, ought to indicate a real teaching of the branches thus virtually promised to be taught, and not be assumed merely in conformity with further usage, or to gratify the temporary whim of a professor, to have an appendage to the title of his chair, which in the very next year he may abandon, and consent to its being appended to some other chair, or to its being omitted entirely in the next annual announcement. We may instance this, attaching physiology to anatomy, the latter being the substantive branch, and of itself taking up the whole time of the professor during the entire session, which is still too short for its legitimate purposes. Still more common and misleading is the appendage of the diseases of women and children to midwifery, and that of medical jurisprudence at one time to materia medica, at another to midwifery, at a third to chemistry.

On motion of Dr. McDOWELL, of Mo., the Association went into Committee of the Whole on the above resolu-

tions, and after debate, reported progress, and asked leave to sit again.

Report of Committee on Medical Literature was referred to the Committee on Publication without reading.

The Committee upon the time and place of next meeting made the following report: That the next meeting of the Association take place in Chicago, Ill., on the 1st Tuesday in June, 1861.

They also nominated for *Secretaries* Drs. S. G. HUBBARD, of Conn., H. A. JOHNSON, of Ill., and the following Committees:

**Committee of Arrangements:**—Drs. DAVIS, FREER, DE LASKIE, ANDREWS, JONES, BEVINS, and BLOODGOOD.

**On Prize Essays:**—Dan'l Brainard, Ill., D. L. McGuigan, Iowa, M. L. Liton, Mo., John Evans, Ill., A. L. McArthur, Ill.

**Committee on Publication.**—F. G. Smith, Pa., Caspar Wister, Pa., S. G. Hubbard, Conn., E. J. Breckenridge, Ky., Edward Hartshorne, Pa., H. F. Askew, Del.

**Vice President.**—In the place of Dr. Logan, resigned, R. D. Arnold, Ga.

The Prize Essay Committee made their report, stating that several communications had been received, but none in their opinion came up to the required standard.

The rules of order, on motion, being suspended, Dr. DAVIS, of Ill., brought forward the 3d resolution which had been offered the day before and laid on the table. After several alterations and amendments, it was adopted as follows:—

**Resolved,** That all essays, voluntary communications, and reports, except those of officers of the Association, reports of committees on medical education, medical literature, and prize essays, shall be first presented to the Association, and referred to the appropriate section, in which they shall be examined and discussed; after which they shall be returned to the secretary of the Association, accompanied by an expression of opinion as to whether they are worthy of publication or not, and the Secretary shall pass all such designated to be worthy directly to the Committee on Publication; and others not so designated shall be retained by the Secretary or returned to their authors, as the latter may indicate.

Dr. LEWIS A. SAYRE read a paper on Morbus Coxarius, which was referred to the Section on Surgery. Several other special committees which were appointed at the last meeting to report on various diseases, were called up, and all those reports which were not laid over, were referred to the several sections.

The Association adjourned.

#### WEDNESDAY AFTERNOON.

The Convention, in accordance with the resolutions of Dr. Davis, passed the day previous, adjourned to meet in sections.

#### THURSDAY MORNING.

The Convention was called to order at 9 o'clock—Dr. WILSON JEWELL, V. P., Chairman.

Dr. ARNOLD, of Ga., in order to facilitate the transaction of business, offered a resolution to the effect, that no member be allowed to speak, or to read an address, which should occupy more than ten minutes. Adopted.

On motion of Dr. SHATTUCK, the rules of order were suspended, in order to give Dr. BOWDITCH, the Chairman of the Committee on the Hunter Memorial, an opportunity to report. The report was referred to the Committee on Nominations.

The Committee appointed by the Association to confer with the Medical Teachers' Convention, made their report. The Chairman, Dr. SHATTUCK, first read the following resolutions, as adopted by the Teachers' Convention:—

1st. **Resolved,** That the Medical Colleges represented in this Convention, are willing to adopt the rule, if it be recommended by the American Medical Association, that every candidate for degree of Doctor of Medicine must present certificates of having assiduously studied medicine during the period of three full years under the direction of a regular practitioner of medicine, recognised as such by the American Medical Association, who shall certify to the same under his own hand, and of attendance on two full courses of medical lectures in a medical school, recognised as regularly organized by the American Medical Association, with an interval of at least three months between the termination of the first course and the commencement of the last.

2d. **Resolved,** That the medical colleges represented in this Convention, are willing to keep a register of their students, in which shall be entered the name, the age, the period of commencing medical studies, and diploma already received, with the name of the college conferring it, and the name of the preceptor.

3d. **Resolved,** That the medical colleges represented in this Convention, allowing that the proposed plan of admitting delegates from State Societies to attend the examination of the candidates for the degree of Doctor in Medicine have been successfully carried out in several places, do not think that it can with advantage be universally adopted; but at the same

time they are ready to entertain and discuss any other measure by which the admission of unsuitable and unworthy members within the ranks of the profession can be prevented.

4th. *Resolved*, That this Convention earnestly recommend the American Medical Association to adopt such measures as will secure the efficient practical enforcement of the standard of preliminary education adopted at its first organization in May 1847, or of a standard put forth by the medical society of the State in which a college is located, and that medical colleges will thankfully receive and record the certificates alluded to in said standard, and one of moral character, whenever the profession generally, and the preceptors will see that students are properly supplied with them.

5th. *Resolved*, That Hospital Clinical instruction constitutes a necessary part of medical education, and that every candidate for the degree of Doctor in Medicine, shall be required to have attended such instruction regularly for a period of not less than four months.

6th. *Resolved*, That the members of this Convention are ready to co-operate in any efforts by which the attention of the community and of legislatures shall be called to the importance of the endowment of medical colleges and professorships.

Dr. SHATTUCK, on the part of the Committee of the Association, offered the following series of resolutions:—

*Resolved*, That it is the duty of medical colleges to require of every candidate for the degree of Doctor in Medicine, certificates of study during the full period of three years, under the direction of a regular practitioner of medicine, recognised by the American Medical Association, who shall certify, under his own hand, as to an attendance on two full courses of lectures, with an interval of at least three months between the termination of the first and the commencement of the second course.

*Resolved*, That every medical college shall keep a volume, in which every medical student presenting himself, shall enter his name, his age, the period of his commencing the study of medicine, any diploma he may have received in evidence of previous education, with the name of the college or school from which he received such diploma; and the name of the preceptor with whom he has been studying.

*Resolved*, That hospital clinical instruction constitutes a necessary part of medical education, and every candidate should be required to have attended such instruction regularly for a period of not less than four months.

*Resolved*, That the professors of every medical college should recommend to their trustees, or board of managers, the adoption of a rule authorizing them to allow the attendance of two or three delegates, from the State Medical Society, at all examinations of candidates for the degree of the doctorate, and accord to these delegates a vote on the question of recommending such candidates for a degree.

*Resolved*, That every State Society be recommended to choose proper delegates at its annual meeting, to attend the examination of candidates for the degree of M.D., at all the medical colleges within their respective States.

*Resolved*, That this Association will not recognise as a regular organization, any college which does not require evidence of suitable preliminary education from all applicants for collegiate medical instruction.

*Resolved*, That we commend the use of all proper efforts, by which the attention of persons of means and liberal disposition, as well as legislative bodies, shall be directed to the propriety of endowing such medical colleges, and professorships thereof, as shall be recognised by the Association.

*Resolved*, That this Association recognise as a regularly organized medical college, one which has been represented at any meeting of this Association, and which complies with the preceding rules and directions.

*Resolved*, That this Association recognise as regular practitioners of medicine, all who have been members of this Association, and have not forfeited their rights and privileges, and all members of State and County Societies, in full standing.

On motion the report was received and the resolutions taken up seriatim. The first elicited much discussion and was finally adopted, with the following amendment by Dr. ATLEE, as a substitute for the last clause: "And no student shall attend a second course of lectures, until a year shall have elapsed since the commencement of the first course." The last resolution was laid on the table, the remainder adopted. The report was then referred to the Committee on Publication.

The following committees, to serve the ensuing year, were reported by the Nominating Committee and accepted:—

*Committee on Medical Literature*.—Drs. FRANK H. HAMILTON, N. Y.; ED. WARREN, Md.; CHAS. A. LEE, N. Y.; J. W. C. ELY, R. I.; E. H. CLARK, Mass.

*Committee on Education*.—Drs. S. T. JOYNES, Va.; C. C. COX, Md.; J. C. BRADBURY, Me.; L. H. STEINER, Md.; and M. A. FATTEN, Mo.

The Nominating Committee also offered the following resolutions:—

*Resolved*, That it be recommended to the different States to collect subscriptions of not more than one dollar each, from every regularly educated physician. All money so collected to be forwarded by the Chairman of the Committee hereby appointed, to the Treasurer of the HUNTER Medical Fund in London.

*Resolved*, That Drs. Henry I. Bowditch, Mass.; Amos Nourse, Maine; George B. Twitchell, N. H.; Charles Clark, Vt.; G. L. Collins, R. I.; Charles Hooker, Conn.; Henry D. Bulkley, N. Y.; Wm. Elmer, N. J.; Jno. L. Atlee, Penna.; James Cowper, Del.; C. C. Cox, Md.; J. B. McCaw, Va.; Cornelius Boyle, D. C.; James H. Dickson, N. C.; H. K. Frost, S. C.; R. D. Arnold, Ga.; John Nott, Ala.; G. A. Nott, La.; W. G. Williams, Mass.; C. A. Page, Mo.; J. B. Lindsay, Tenn.; R. J. Breckenridge, Ky.; J. W. Russell, Ohio; A. B. Palmer, Michigan; Calvin West, Ind.; Patrick Gregg, Ill.; D. L. McGugin, Iowa; J. B. Douseman, Wis.; D. W. Hand, Minn.; O. Harvey, Cal.; F. G. McParack, Ark., be a committee to collect subscriptions.

A copy of the above resolutions was directed to be sent to the medical schools throughout the country.

A resolution was passed that the Association give its seal to each medical school in good standing, with the power of reclaiming the same upon sufficient evidence that the school was no longer entitled to its possession. Adjourned.

#### THURSDAY AFTERNOON—CLOSING SESSION.

The Association met at 4 P.M., WILSON JEWELL in the chair.

Several reports on the Secretary's table were referred to the Committee on Publication with power.

The various papers reported from the sections were referred to the Committee on Publication.

The Essex Co. Medical Society of the State of New Jersey presented the following preamble and resolutions:

*Whereas*, The indiscriminate sale of poisonous drugs at retail is fraught with danger to the community; be it

*Resolved*, That in the opinion of this Association, it is the duty of the public authorities in the different States of the Union, to pass prohibitory laws against the retailing of morphia, strychnine, prussic acid, etc., except on the written prescription of a regular practitioner of medicine, or on the personal application of a well-known citizen—and that a committee be appointed in the different States, to endeavor to carry into effect the spirit of the resolutions.

The paper was received and the resolutions adopted.

The report was referred to the Committee on Publication with power.

Dr. A. N. DOUGHERTY, from the Committee on Tracheotomy, reported, and at his own request the report was referred back to the committee, with power to complete the report.

Resolutions tendering the thanks of the Association to the profession and citizens of New Haven for their hospitalities were passed, when the Association adjourned.

#### DEATHS.

ISAACS, Charles E., M.D., Saturday, June 16, at Brooklyn, N. Y., aged about 43.

A biographical sketch will appear in the next number.

RICHARDS, Joseph B., M.D., Senior Assistant Physician to Bellevue Hospital, N. Y., Monday, June 4.

Dr. Richards was a native of Oneida County, N. Y. He studied his profession with Dr. Guitteau, of Trenton, and attended his first course of lectures at the Albany Medical College; subsequently he attended two courses at the College of Physicians and Surgeons, from which school he graduated. He entered Bellevue Hospital Oct. 1, 1859, and had just commenced his term of service as Senior Assistant Physician when he was suddenly attacked with peritonitis, the result of perforation of the appendix vermiformis, of which he died after a short but painful illness. Dr. Richards was greatly esteemed by his associates.

#### MEDICAL DIARY OF THE WEEK.

Monday, July 9.	{ CITY HOSPITAL, Surgery, Dr. Watson, half-past 1 P.M. BELLEVUE, Obstetrics, Dr. Elliot, half-past 1 P.M. EYE INFIRMARY, Diseases of Eye, 12 M.
Tuesday, July 10.	{ BELLEVUE, Medicine, Dr. Thomas, half-past 1 P.M. CITY HOSPITAL, Surgery, Dr. Parker, half-past 1 P.M. EYE INFIRMARY, Diseases of Ear, 12 M. OPHTHALMIC HOSPITAL, Drs. Stephenson & Garrish, 1 P.M.
Wednesday, July 11.	{ ACADEMY OF MEDICINE, 8 P.M. EYE INFIRMARY, Operations, 12 M. CITY HOSPITAL, Medicine, Dr. Bulkley, half-past 1 P.M. BELLEVUE, Surgery, Dr. Sayre, half-past 1 P.M.
Thursday, July 12.	{ OPHTHALMIC HOSPITAL, Drs. Stephenson & Garrish, 1 P.M. CITY HOSPITAL, Surgery, Dr. Watson, half-past 1 P.M. BELLEVUE, Medicine, Dr. Loomis, half-past 1 P.M.
Friday, July 13.	{ CITY HOSPITAL, Surgery, Dr. Parker, half-past 1 P.M. EYE INFIRMARY, Diseases of Eye, 12 M.
Saturday, July 14.	{ BELLEVUE, Surgery, Dr. Church, half-past 1 P.M. OPHTHALMIC HOSPITAL, Drs. Stephenson & Garrish, 1 P.M. CITY HOSPITAL, Medicine, Dr. Bulkley, half-past 1 P.M. EYE INFIRMARY, Diseases of Ear, 12 M.

